

Protecting, Maintaining and Improving the Health of All Minnesotans

September 15, 2022

Administrator Falls Landing Assisted Living 1101 North Hiawatha Avenue Pipestone, MN 56164

RE: Project Number(s) SL30347015

Dear Administrator:

On September 9, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the June 10, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jodi Johnson, Supervisor State Evaluation Team Health Regulation Division 85 East Seventh Place, Suite 220

P.O. Box 3879

St. Paul, MN 55101-3879

Telephone: 507-344-2730 Fax: 651-215-9697

**PMB** 



Protecting, Maintaining and Improving the Health of All Minnesotans

**Electronically Delivered** 

July 21, 2022

Administrator
Falls Landing Assisted Living
1101 North Hiawatha Avenue
Pipestone, MN 56164

RE: Project Number(s) SL30347015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 10, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . . "

## **IMPOSITION OF FINES**

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

- Level 1: no fines or enforcement.
- Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
- Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
- Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of \$1,000 for each substantiated maltreatment violation

Falls Landing Assisted Living July 21, 2022 Page 2

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

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St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration = $3,000
St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000
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The total amount you are assessed is \$6,500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

## **DOCUMENTATION OF ACTION TO COMPLY**

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

## **CORRECTION ORDER RECONSIDERATION PROCESS**

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Falls Landing Assisted Living July 21, 2022 Page 3

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

## **REQUESTING A HEARING**

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to Health.HRD.Appeals@state.mn.us.

To appeal fines via reconsideration, please follow the procedure outlined above. <u>Please note that you may request a reconsideration or a hearing, but not both.</u>

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor

State Evaluation Team
Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 3879

St. Paul, MN 55101-3879

Telephone: 507-344-2730 Fax: 651-215-9697

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING.	·	
		30347	B. WING		06/10/2022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
FALLS L	ANDING ASSISTED L	IVING	TH HIAWAT NE, MN 561	HA AVENUE 64	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
0 000	Initial Comments		0 000		
	In accordance with 144G.08 to 144G.9 issued pursuant to Determination of where the start when Minnesota Stailure to comply with considered lack of INITIAL COMMENTSL30347015-0  On June 6, 2022, the Minnesota Departm survey at the above correction orders as survey, there were received services; the Living license.  On June 6, 2022, a was identified for Stailer identification 1750 a identificatio	PROVIDER LICENSING DER(S)  Minnesota Statutes, section 5, these correction orders are a survey.  hether violations are corrected with all requirements tute number indicated below. tatute contains several items, th any of the items will be compliance.  TS:  Trough June 10, 2022, the nent of Health conducted a provider, and the following re issued. At the time of the 17 residents, all of whom under the provider's Assisted  In immediate correction order 0347015-0, tag identification colated (G).  In immediate correction order		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Assis Living License Providers. The asstag number appears in the far left entitled "ID Prefix Tag." The state number and the corresponding testate Statute out of compliance is the "Summary Statement of Defic column. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Column STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FEDERAL DEFICIENCIES ONLY WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTIONS OF MINNESOTA STATUTES.  The letter in the left column is use tracking purposes and reflects the and level issued pursuant to 1440 subd. 1, 2, and 3.	oftware. to sted signed column Statute ct of the listed in encies" s the le state This as eyors' rection.  DING OF THIS  O DN FOR TATE  d for scope
0 250 SS=F	144G.20 Subdivision	on 1 Conditions	0 250		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		30347	B. WING		06/1	0/2022
NAME OF I	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00.1	<u> </u>
		1101 NOR		HA AVENUE		
FALLS L	ANDING ASSISTED L	IVING	NE, MN 5610			
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0 250	Continued From pa	ge 1	0 250			
0 230	(a) The commission provisional license, result of a change is a license, suspend a conditional license individual, or employ facility:  (1) is in violation of, license has violated this chapter or adoption (2) permits, aids, or illegal act in the proservices;  (3) performs any act safety, and welfare  (4) obtains the licent misrepresentation;  (5) knowingly make material fact in the any other record or chapter;  (6) denies represent access to any part of files, or employees;  (7) interferes with othe department in cresidents;  (8) interferes with othe department in the department i	ner may refuse to grant a refuse to grant a license as a nownership, refuse to renew or revoke a license, or impose if the owner, controlling yee of an assisted living or during the term of the lit, any of the requirements in oted rules; rabets the commission of any vision of assisted living of a resident; ase by fraud or a false statement of a application for a license or in report required by this attatives of the department of the facility's books, records, or impedes a representative of ontacting the facility's remedes ombudsman of section 256.9742, or impedes a representative of the enforcement of this chapter erate with an inspection, tion by the department; alkes unavailable any records the lating to the assisted living the with this chapter; are a background study under	0 250			

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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- ALLO L	T	PIPESTON	NE, MN 5610			
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0 250	Continued From pa	ige 2	0 250			
	commissioner; (13) violates any local relating to housing (14) has repeated in performing services level; or (15) has operated by a sassisted living facility.  This MN Requirements by: Based on interview licensee failed to shoof licensure, by attempts who oversaw the day and erstood applicated developed and/or in and procedures as	pay any fines assessed by the cal, city, or township ordinance or assisted living services; ncidents of personnel is beyond their competency beyond the scope of the city's license category. Contractor providing the cices of the facility is a violation ent is not met as evidenced and record review, the now they met the requirements esting the managerial officials ay-to-day operations ble statutes and rules; nor implemented current policies required with records the potential to affect all divisitors.				
	violation that did no safety but had the president's health or cause serious injur- is issued at a wides are pervasive or re	ed in a level two violation (a of harm a resident's health or cotential to have harmed a safety, but was not likely to y, impairment, or death), and spread scope (when problems present a systemic failure that the potential to affect a large residents).				
	The findings include	e:				
	at approximately 9:	e conference on June 6. 2022, 18 a.m. licensed assisted D)-A stated the licensee's				

Minnesota Department of Health

STATE FORM 5699 ZQBT11 If continuation sheet 3 of 105

STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION			DER/SUPPLIER/CLIA FICATION NUMBER:	, ,	E CONSTRUCTION		SURVEY PLETED
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with the ass licensee promanagement. The license License, see Owner or Air the application and understiplaced beformulated beformulated. I have read [Minnesota] 144G.45, more subdivisions section Law [session]., condition of the condition of th	in chargisted lively living Lier living Li	ge of the faring regular nedication ces. lication for ed Official of Agent, (pentified, I constitute) section (and the section of the following: a fattute] section (b) must the section (c) must the	tand Minn.  ct. [section] ccomply with n, as applicable [special] Sess rt. [article] 6, sect.  tand Minn. Stat. Laws 2020, 7th	0 250			

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Minnesota Department of Health

Millinesc	ita Department of He	eaith				
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		1101 NOR	TH HIAWAT	HA AVENUE		
FALLS L	ANDING ASSISTED L	IVING PIPESTOI	NE, MN 561	64		
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0 200	Continued From pa	ge <del>-</del>	0 200			
		rmine if the applicant meets				
	requirements for assisted living licensing. I					
	understand I am not legally required to supply the					
	requested information; however, failure to provide					
	information or the submission of false or					
	misleading information may delay the processing					
	of my application or may be grounds for denying					
		and that information submitted				
		er in this application may, in				
	some circumstances, be disclosed to the					
	appropriate state, federal or local agency and law					
		to enhance investigative or				
		or further a public health				
		Types of offices include Adult				
		, offices of the ombudsmen,				
		ards, Department of Human				
		city attorneys' offices, police,				
	local or county publ	ic health offices.				
		cordance with Minn. Stat.				
		Relating to Licensed and				
		s (opens in a new window), all				
		his application shall be				
	· ·	information upon issuance of				
	•	e or license. All data submitted				
	license.	ate until MDH issues a				
	licerise.					
	I declare that as t	he owner or outhorized agest				
		the owner or authorized agent, read Minn. Stat. chapter 144G,				
		•				
		es, chapter 4659 governing sisted living facilities, and				
		icensee I am legally				
		management, control, and illity, regardless of the				
		agement agreement or				
	subcontract.	agement agreement of				
	Subcontiact.					
	- I have examined t	his application and all				
		necked the above boxes				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			A. BUILDING.			
		30347	B. WING		06/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWATI NE, MN 5616			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
0 250	Continued From pa	age 5	0 250			
	Minnesota Statutes related to assisted my knowledge and true, correct, and couriting, of any char required.	w and understanding of s, Rules, and requirements living licensure. To the best of believe, this information is omplete. I will notify MDH, in nges to this information as				
	procedures of Minn Minn. Rules chapte	required policies and n. Stat. chapter 144G and er 4659 in place upon licensure current as applicable.				
	The licensee had an assisted living license issued on August 1, 2021, with an expiration date of July 31, 2022.					
	policies and proced implemented: (3) orientation, trainevaluations of staff staff performance; (6) conducting initiatevaluations and assincluding assessment appropriate licenses changes in a residemanaged, and combealth care provide (7) orientation to an assisted living bill of (8) infection control (10) conducting application of pataff are free of tub current United State and Prevention staff (12) medication and	nd implementation of the of rights; I practices; propriate screenings, or orior screenings, to show that erculosis, consistent with es Centers for Disease Contro				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED	
		30347	B. WING		06/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWATI NE, MN 5610	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
0 250	As a result of this s were issued 0510, 01470, 1530, 1620, 1830, 1890, 1910, indicating the licens Minnesota statutes compliance with Minduck 144G.08 to 144G.9	fessionals; and unlicensed personnel ed tasks. urvey, the following orders 0660, 0700, 1370, 1380, 1440, 1650, 1700, 1710, 1730, 1750, 1940, 1950, 1970, and 2310, see's understanding of the were limited, or not evident for nnesota Statutes, section 5.	0 250			
0 470 SS=F	(11) develop and im determining its staff (i) includes an evaluleast twice a year, of staffing levels in the (ii) ensures sufficient the scheduled and unscheduled needs by the residents' as on a 24-hour per da (iii) ensures that the and effectively to in and to emergency, situations affecting (12) ensure that one available 24 hours purchased in the staff of the staff	partion, to be conducted at of the appropriateness of a facility; and staffing at all times to meet reasonably foreseeable of each resident as required sessments and service plans as basis; and a facility can respond promptly dividual resident emergencies life safety, and disaster staff or residents in the facility; are or more persons are over day, seven days per week, as for responding to the ts for assistance with health or	0 470			

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		SURVEY PLETED
		30347	B. WING		06/	10/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	ORTH HIAWATH ONE, MN 5616			
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0 470	(i) awake; (ii) located in the sabuilding, or on a cofacility in order to reamount of time; (iii) capable of com(iv) capable of provappropriate assistation (v) capable of follows: This MN Requirem by: Based on observative review, the licenses staffing plan was dipotentially affecting and any visitors of facility failed to poscentral location, the residents, voluntees. This practice result violation that did no safety but had the president's health or cause serious injur was issued at a wide problems are pervafailure that has affer a large portion or a superioristic remains a large portion or a superioristic remains a large portion or a superioristic remains a large for a capacity current census of 1.	ame building, in an attached ontiguous campus with the espond within a reasonable amunicating with residents; viding or summoning the ince; and wing directions; ent is not met as evidenced ion, interview and record e failed to ensure the required eveloped as required, at the licensee. In addition, the set a staffing schedule daily in a fat was accessible to staff, ars, and the public.  Ited in a level two violation (a soft harm a licensee's health or potential to have harmed a resafety, but was not likely to the exist of the residents).  The exist of the residents is a sassisted living license, was acity of 28 residents, and had a soft of the residents.				

Minnesota Department of Health

TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  O 470  Continued From page 8  twice a year, of the appropriateness of staffing levels in the facility; - ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and - ensured that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. In addition, the facility failed to post a staffing schedule daily in a central location, that was accessible to staff, residents, volunteers, and the		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
Talls Landing Assisted Living   Tall   North Hiawatha Avenue			30347	B. WING		06/	10/2022	
CX4)   ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PREFIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   DATE DEFICIENCY)   DATE DEFICIENCY)   DATE DEFICIENCY   DATE DEFIC	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  O 470  Continued From page 8  twice a year, of the appropriateness of staffing levels in the facility; - ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and - ensured that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. In addition, the facility failed to post a staffing schedule daily in a central location, that was accessible to staff, residents, volunteers, and the	FALLS L	ANDING ASSISTED L	IVING					
twice a year, of the appropriateness of staffing levels in the facility; - ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and - ensured that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. In addition, the facility failed to post a staffing schedule daily in a central location, that was accessible to staff, residents, volunteers, and the	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI	HOULD BE	COMPLETE	
On June 6, 2022, during the entrance conference at 9:18 a.m. licensed assisted living director (LALD)-A indicated the licensee had not developed a staffing plan.  On June 6, 2022, at 10:52 a.m. a white board was noted in the dining room. It was dated May 31, 2022, and identified "kitchen 7A-7P 1 staff", "resident aide 7A-7P - 1 staff, and 7P-7A- 1 staff", and "RN available 24/7/365". The whiteboard failed to be updated daily with the staffing schedule for that day.  The licensee's Staffing Requirements -licensed nurse and ULP (unlicensed personnel) policy dated August 1, 2021, identified "A!I staff of [the facility] persons providing assisted living services must be trained and competent in the provision of services consistent with current practice standards appropriate to the resident's needs and promote and be trained to support the assisted living bill of rights." It failed to include the required content.	0 470	twice a year, of the levels in the facility; - ensured sufficient the scheduled and unscheduled needs by the residents' as on a 24-hour per da - ensured that the fand effectively to in and to emergency, situations affecting In addition, the faci schedule daily in a accessible to staff, public.  On June 6, 2022, dat 9:18 a.m. license (LALD)-A indicated developed a staffing.  On June 6, 2022, a was noted in the dia 31, 2022, and ident "resident aide 7A-7 and "RN available 2 failed to be updated schedule for that da The licensee's Staff nurse and ULP (undated August 1, 202 facility] persons promust be trained and services consistent standards appropria promote and be tralliving bill of rights."	appropriateness of staffing staffing at all times to meet reasonably foreseeable of each resident as required sessments and service plans ay basis; and acility can respond promptly dividual resident emergencies life safety, and disaster staff or residents in the facility. lity failed to post a staffing central location, that was residents, volunteers, and the  uring the entrance conference ed assisted living director the licensee had not g plan.  t 10:52 a.m. a white board ning room. It was dated May ified "kitchen 7A-7P 1 staff", P - 1 staff, and 7P-7A- 1 staff", P24/7/365". The whiteboard d daily with the staffing ay.  fing Requirements -licensed licensed personnel) policy 21, identified "A!I staff of [the oviding assisted living services d competent in the provision of with current practice ate to the resident's needs and ined to support the assisted	0 470				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
712 . 271	o. cozo		A. BUILDING:			
		30347	B. WING		06/1	0/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWAT NE, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 470	Continued From pa	ge 9	0 470			
	No further informati	on was provided.				
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days					
0 480 SS=F	144G.41 Subd 1 (1) requirements	3) (i) (B) Minimum	0 480			
	(13) offer to provide following services to	e or make available at least the presidents:				
	available seven day recommended dieta States Department	ritious meals daily with snacks is per week, according to the ary allowances in the United of Agriculture (USDA) g seasonal fresh fruit and he following apply:				
		repared and served according good Code, Minnesota Rules,				
	by: Based on observatireview, the licensee prepared and serve	ent is not met as evidenced on, interview and record e failed to ensure food was ed according to the Minnesota ad the potential to affect all 17 at the facility.				
	violation that did no safety but had the p resident's health or	ed in a level two violation (a t harm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/1	0/2022
	PROVIDER OR SUPPLIER  ANDING ASSISTED L	IVING 1101 NOR	DRESS, CITY, S TH HIAWATI NE, MN 5610			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 480	problems are perva failure that has affe a large portion or al The findings include Please refer to the and Beverage Esta	despread scope (when sive or represent a systemic cted or has potential to affect I the residents).  De:  Included document titled, Food blishment Inspection Report, for the specific Minnesota cies.  R CORRECTION:	0 480			
0 510 SS=F	(a) All assisted livin maintain an infection complies with acceluration and the complies with acceluration and the consistent with curronational Centers for Prevention (CDC) from the control in long-term applicable, for infection assisted living facility (c) The facility must compliance with this This MN Requirements by:  Based on observation review, the licenses maintain an effective that complies with a and nursing standards.	ction control program must be ent guidelines from the Disease Control and or infection prevention and care facilities and, as tion prevention and control in ties.	0 510			

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30347	B. WING		06/1	0/2022
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/1	OIZOZZ
	ANDING ASSISTED L	IVING 1101 NOR	RTH HIAWATI	HA AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 510	MDH guidance for appropriate PPE (p Staff failed to screet the building for their to perform hand hy medication administ monitoring, and perpotential to affect a visitors.  This practice result violation that did not safety but had the president's health or cause serious injuring is issued at a wides are pervasive or rechast affected or has portion or all of the The findings includ.  The findings includ.  The findings includ.  The licensee failed contact with resident personal protective. Centers for Diseas Minnesota Departing guidelines.  On June 6, 2022, a licensed assisted lifollowing was observaning any eye pregistered nurse (I residents. She was not wearing eye prohousekeeping (HS resident apartment)	COVID-19 related to wearing personal protective equipment). In for COVID-19 when entering r shift. In addition, staff failed giene after completing stration, blood glucose resonal cares. This had the ll current residents, staff and led in a level two violation (a personal to have harmed a resident's health or cotential to have harmed a resident, but was not likely to by, impairment, or death), and represent a systemic failure that the potential to affect a large residents).  The ensure employees in direct a the potential to affect a large residents).  The econtrols (CDC) and the equipment (PPE) as per the ending a face mask, but was not otection; and affect in the was interacting with the wearing a face mask but was not otection; and affect mask on her swearing a face mask on	0 510			
		s wearing a face mask on her or the mouth and nose, and				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/	10/2022
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	FALLS LANDING ASSISTED LIVING PIPESTO					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
0 510	was not wearing eye-unlicensed personal face mask, but was heat was heat was heat was heat was heat was heat was not wask, but was not wask, but was not was not was not wearing eye exited the room and personal cares durithe room completin ULP-C exited the rohallway with her macover the mouth an At 11:16 a.m., she was not wearing eye heat was not wearing eye exited the room completin ULP-C exited the rohallway with her macover the mouth an At 11:16 a.m., she was medication to R2, a medication to R4. Shut no eye protection COVID-19, staff we mask. If there were were to wear a gow gloves when caring ULP-C entered the entrance and then we complete her scree on June 6, 2022, a were passing out pl HSK-G was wheeling KC-F, AD-H, and H but failed to wear eye on June 6, 2022, a were passing out pl HSK-G was wheeling KC-F, AD-H, and H but failed to wear eye on June 6, 2022, a were passing out pl HSK-G was wheeling KC-F, AD-H, and H but failed to wear eye on June 6, 2022, a were passing out pl HSK-G was wheeling KC-F, AD-H, and H but failed to wear eye on June 6, 2022, a were passing out pl HSK-G was wheeling KC-F, AD-H, and H but failed to wear eye on June 6, 2022, a were passing out pl HSK-G was wheeling KC-F, AD-H, and H but failed to wear eye on June 6, 2022, a were passing out pl HSK-G was wheeling KC-F, AD-H, and H but failed to wear eye on June 6, 2022, a were passing out pl HSK-G was wheeling KC-F, AD-H, and H but failed to wear eye on June 6, 2022, a were passing out pl HSK-G was wheeling KC-F, AD-H, and H but failed to wear eye on June 6, 2022, a were passing out pl HSK-G was wheeling KC-F, AD-H, and H but failed to wear eye on June 6, 2022, a were passing out pl HSK-G was wheeling KC-F, AD-H, and H but failed to wear eye on June 6, 2022, a were passing out pl HSK-G was wheeling KC-F, AD-H, and H but failed to wear eye on June 6, 2022, a were passing out pl HSK-G was wheeling KC-F, AD-H, and H but failed to wear eye on June 6, 2022, a were passing out pl HSK-G was wheeling KC-F, AD-H, and H but failed to wear ey	e protection; nel (ULP)-C was wearing a not wearing eye protection; r (KC)-F was wearing a face wearing eye protection; and AD)-H was wearing a face wearing eye protection.  t approximately 10:50 a.m. on and RN-B entered R1's as wearing a face mask, but e protection. At 11:03 a.m. she d stated she had to perform ng his shower. ULP-C was in g the shower. At 11:10 a.m., bom and was walking in the lisk below the chin, failing to d nose, and no eye protection. was observed administering nd at 11:50 she administered she was wearing a face mask, bon. ULP-C stated that since re required to wear a face a positive resident, then they ren, mask, eye protection, and for the positive resident. building through a staff walked to the front entrance to ning.  t 12:00 p.m. KC-F and AD-H ates of food to the residents. ng a resident to the table. SK-G were wearing masks,	0 510			
		nd complete the COVID-19				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ' '		(X3) DATE	SURVEY LETED
71101 1211	OF GOTTLESTION	IDENTIFICATION NOWBER.	A. BUILDING:		OOWII	
	30347		B. WING		06/1	0/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	TH HIAWATI NE, MN 5610			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
0 510	Continued From pa	ge 13	0 510			
	Staff were expected mask at all times. V staff were to wear g and gloves. Current positive cases, so or required.  On June 7, 2022, at the dining room, ale the front entrance. If from the kitchen are room, passing within entrance. ULP-D we eye protection. She come in, and begar informed ULP-D of COVID-19. ULP-D of COVID-19. ULP-D rewearing, and ther room. She walked p shoulder. ULP-D rewearing a face mas 6:30 a.m., ULP-D we mask and gloves are entered R4's room ULP-D removed the hand hygiene. ULP-applied gloves. UL administered oral m blood glucose testir applying their knee ULP-D removed he medication cart with	d to wear a medical grade face When they had an outbreak, gown, mask, eye protection tally, they did not have any only a "face mask" was  t 6:15 a.m. R10 was noted in erting staff that surveyor was in ULP-D was observed walking and through the dining in two feet of R10, to the front as not wearing a face mask or instructed the surveyor to into walk away. The surveyor the screening requirement for completed the surveyor's in went to get a key to open a past R10 and patted his turned carrying a key and each, but no eye protection. At was noted to be wearing a and carrying eye drops. ULP-D and administered eye drops. Fir gloves, but failed to perform the serior and patted to perform the dication and completed ing. ULP-D assisted R8 with braces and getting dressed. It gloves and returned to the mout performing hand hygiene. It garden as a face mask, but no eye				
	On June 7, 2022, a KC-F was noted in	t approximately 7:00 a.m. the kitchen setting up for (C-F failed to wear a mask or				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/	10/2022
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	NE, MN 5616			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
0 510	Continued From pa	ge 14	0 510			
	On June 7, 2022, at 7:10 a.m. LALD-A stated staff should be wearing a medical grade mask at all times.  The licensee's 2019-2021 Coronavirus Staff Evaluation Tool identified a coronavirus risk assessment with columns that included date and time, temperature, recent travel, recent exposure, and staff initials.  ULP-D's staff schedule indicated she worked on June 4, 2022, 7:00 p.m. until 7:00 a.m., June 5, 2022, 7:00 p.m. until 4:00 a.m., and June 6, 2022, 10:00 p.m. until 7:00 a.m. ULP-D's 2019-2021 Coronavirus Staff Evaluation Tool for June 2022, identified no screenings had been completed.					
	through the activity kitchen where numer the tables. She set container at a table She then walked do resident rooms letti breakfast and assist walked past R11 in about coming to breakfast. She was eye protection. HSP Staff Evaluation Too COVID screening ha.m., HSK-G return	t 7:29 a.m. HSK-G walked area, hallway and into the erous residents were sitting at her personal beverage that a resident was sitting at. own the hallway entering and them know to come to sting them as needed. She the hall and talked to her eakfast. She entered R12 and et them know to come to not wearing a face mask or K-G's 2019-2021 Coronavirus of for June 2022, identified ad been completed. At 7:33 ed to the front entry, placed a spleted the COVID screening				
	and gloves, but faile	t 8:41 a.m. ULP-E rops to R8. She wore a mask ed to wear eye protection.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
30347		30347	B. WING		06/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	TH HIAWATI NE, MN 5610			
(X4) ID PREFIX TAG	4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	.D BE	(X5) COMPLETE DATE
0 510	were to wear a mass RN-B stated she was wearing a mask. She regarding mask used unaware of the currifor eye protection. Sentering the building were required to so shift. At 12:21 p.m., wash hands or use after cares, in betwe soiling, after remove and after pericares.  On June 7, 2022, the transmission level of MDH's COVID-19 of identified facilities were protection during transmission rates.  The licensee's Glove 2021, identified "Glothere may be direct employee and containstructed."  "Procedure:  1. Wash hands  2. Apply gloves to 3. Remove containstructed."  "Procedure:  1. Wash hands  2. Apply gloves to 3. Remove containstructed."  "Procedure:  1. Wash hands  2. Apply gloves to 3. Remove containstructed."  "Procedure:  1. Wash hands  2. Apply gloves to 3. Remove containstructed."  "Procedure:  1. Wash hands  2. Apply gloves to 3. Remove containstructed."	and hygiene.  It 9:26 a.m. RN-B stated staff sk at all times when working. It as not surprised staff were not the had completed education in the rent MDH and CDC guidelines in the beginning of their in the beginning of their in the stated staff were to hand sanitizer before and in the endication passes, after in the gloves, after oral cares in the complete in the proper county was high. The proper to wear a face mask and in the proper state in the proper receptacle in the proper receptacle is by grasping cuff of one glove on the proper receptacle. In the proper receptacle in the proper receptacle.	0 510			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30347	B. WING		06/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
FALLSI	FALLS LANDING ASSISTED LIVING 1101 NO			A AVENUE		
TALLO L	AND IN CAUCIOTED E	PIPESTON	NE, MN 5610	64		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CO		(X5) COMPLETE DATE
0 510	Continued From pa	ge 16	0 510			
	August 1, 2021, ide techniques should be of infection. Hand we also before, during, and a Before eating food a Before and after to a Stern blowing your a After blowing your a After blowing your a After touching and a Before and When conducting an a Before and When conducting a before do a Before and to be a Before and washing soiled. However, if soap and water are alcohol-based hand least 60% alcohol in the number of germ to the number of germ to the number of germ to the number of tin must use soap and though, is to wash whands are visibly so for someone with cothe hands have a "form to the hands have	aring for someone who is sick reating a cut or wound et upers or cleaning up after used the toilet rose, coughing, or sneezing animal or animal waste food or pet treats bage" Gloves procedure requiring the use and hygiene should be onning gloves and after  d Sanitizers (ABHS) e used as a replacement for any when hands are visibly hands are not visibly soiled, or not available, an a sanitizer that contains at any be used to quickly reduce as on hands. There is no limit thes you use ABHS before you water. A good rule of thumb with soap and water when oiled, after completing cares. diff or norovirus, and when				
	2021, identified "Ma mucous membrane	ks policy dated August 1, asks are worn to protect the s of the eyes, nose and mouth and tasks that are likely to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/	10/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	TH HIAWATI NE, MN 5616	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
0 510	generate splashes of secretions or excretions or excretions or excretions. The licensee's Stan August 1, 2021, ide precautions will be a providing housekee to residents. The M Health and/or CDC followed unless other than the facility provided control/prevention. Personal Protective Congregate Care S and COVID-19 University Assessment for Lor Living-type Settings was not completed. The current recommendation of the current recommendation of the course of the secretary of the sec	or sprays of blood, body fluids, cions."  dard Precautions policy dated ntified "To ensure standard used by all staff when ping or maintenance services innesota Department of recommendations will be er guidelines are set forth."  d a binder labeled infection Noted in the binder COVID-19 Equipment (PPE) Grid for ettings dated June 30, 2021, versal Eye Protection Risk ng-term Care and Assisted date June 25, 2021, which The binder failed to contain endations	0 510			
0 580 SS=F	The facility shall end appropriate to the site to the type of service management activities quality of care by perservices, complaints have occurred and in services, staffing be made in order to services to resident	uality management gage in quality management ize of the facility and relevant es provided. "Quality y" means evaluating the eriodically reviewing resident s made, and other issues that determining whether changes or other procedures need to ensure safe and competent s. Documentation about t activity must be available for	0 580			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. Bolebino.			
		30347	B. WING		06/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	TH HIAWATI NE, MN 5610			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 580	Continued From pa	ge 18	0 580			
	two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.					
	by:	ent is not met as evidenced and record review, the				
	licensee failed to in quality managemer size of the facility a services provided.	nplement and maintain a nt program appropriate to the nd relevant to the type of This had the potential to affect s, staff, and visitors.				
	This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).					
	The findings include	ed:				
	at 9:18 a.m. license (LALD)-A stated sh registered nurse re	uring the entrance conference ed assisted living director e had meetings with the garding falls; however, the eet the requirements.				
	dated August 1, 202 will have at least or management project	lity Management Project policy 21, identified "[the licensee] ne documented quality ct in place at all times, and ich projects for at least two				
	Management" is:	iving requirement for "Quality gage in quality management				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	COMPLETED		
		30347	B. WING		06/1	0/2022
NAME OF				OTATE ZID CODE	1 00/1	UIZUZZ
NAME OF	PROVIDER OR SUPPLIER		CTH HIAWATI	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	NE, MN 5616			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 580	appropriate to the s to the type of service management activit quality of care by pe services, complaint have occurred and in services, staffing be made in order to services to resident quality management two years. Informat must be available to of the survey, inves	ize of the facility and relevant tes provided. "Quality ty" means evaluating the eriodically reviewing resident is made, and other issues that determining whether changes, or other procedures need to ensure safe and competent is. Documentation about activity must be available for ion about quality management of the commissioner at the time tigation, or renewal."	0 580			
0 650 SS=F	(a) The facility must each paid employed volunteer providing contractor providing include the following (1) evidence of curr registration, or certi registration, or certi chapter or rules; (2) records of orient and infection control evaluations; (3) current job description qualifications, responsible to the control of t	t maintain current records of e, each regularly scheduled services, and each individual g services. The records must g information: ent professional licensure, fication if licensure, fication is required by this tation, required annual training of training, and competency cription, including consibilities, and identification of ling supervision; of annual performance or areas of improvement	0 650			

Minnesota Department of Health STATE FORM

M Solution Sheet 20 of 105

STATEMEN <sup>*</sup>	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/1	0/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
FALLS LA	ANDING ASSISTED L	IVING	TH HIAWATI NE, MN 5610	HA AVENUE 64		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 650	services, verification screenings under sign and the dates of the (6) documentation of required under sect (b) Each employee least three years aftivolunteer, or contraby, provide services the facility. If a facility employee records in years after facility on this MN Requirements by:  Based on interview licensee failed to encontained the requiremployees (unlicen ULP-D, and register this practice results violation that did not safety but had the president's health or widespread scope (or represent a system or has the potential of the residents).  The findings include ULP-C ULP-C's personnel March 23, 2021.	roviding assisted living in that required health subdivision 9 have taken place ose screenings; and of the background study as ion 144.057. record must be retained for at ter a paid employee, ctor ceases to be employed at, or be under contract with ty ceases operation, must be maintained for three perations cease.  The entire is not met as evidenced and record review, the issure the employee record red content for three of three sed personnel (ULP)-C and red nurse (RN)-B reviewed.  The entire is not met as evidenced as a level two violation (at harm a resident's health or intential to have harmed a safety) and was issued at a when problems are pervasive emic failure that has affected to affect a large portion or all record lacked evidence of a record lacked evidence of a record lacked evidence of a	0 650			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/1	0/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	FALLS LANDING ASSISTED LIVING  1101 NO PIPESTO			HA AVENUE 64		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 650	Continued From pa	ge 21	0 650			
	ULP-D ULP-D's personnel file identified she was hired on June 11, 2018.					
	ULP-D's employee record identified she had performance evaluations on December 11, 2018, December 20, 2019, and December 16, 2020. There was no evidence a performance evaluation had been completed in the last year.					
	RN-B RN-B's personnel file identified she was hired on December 24, 2019.					
	performance evalua	ecord identified she had a ation on December 23, 2020. ence a performance evaluation d in the last year.				
	On June 10, 2022, at approximately 9:00 a.m. licensed assisted living director (LALD)-A stated she was in charge of annual performance evaluations for the nurse, housekeeping, and kitchen staff. RN-B was responsible for completing on them on the ULP staff.					
	gave completed an	at 10:44 a.m. RN-B stated she nual performance evaluations vere not in the employee files een completed.				
	August 1, 2021, ide each person will ind performance review	ployee Records policy dated entified employee records for clude documentation of annual ws that identify areas of ed and training needs.				
	No further informat	ion was provided.				
	TIME PERIOD FOR	CORRECTION:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		30347	B. WING		06/1	0/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	FALLS LANDING ASSISTED LIVING PIPESTO			HA AVENUE 64		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 650	Continued From pa	ge 22	0 650			
	Twenty-One (21) da	ays				
0 660 SS=D	144G.42 Subd. 9 T control	uberculosis prevention and	0 660			
	<ul> <li>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.</li> <li>(b) The facility must maintain written evidence of compliance with this subdivision.</li> </ul>					
	by: Based on interview licensee failed to estuberculosis (TB) p the most current gu for Disease Contro included document history and sympto completion of a two test) or other evider	and record review, the stablish and maintain a revention program, based on uidelines issued by the Centers I and Prevention (CDC) which ation of a completed health m screening, including obstep TST (tuberculin skin nee of TB screening such as a of three employees (registered records reviewed.				
	violation that did no	ed in a level two violation (a ot harm a resident's health or ootential to have harmed a				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
30347		B. WING		06/10/2022		
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
FALLS LANDING ASSISTED LIVING		TH HIAWATI NE, MN 5616				
(X4) ID SUMMARY STATEMENT OF DEFI PREFIX (EACH DEFICIENCY MUST BE PRECE TAG REGULATORY OR LSC IDENTIFYING I	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
resident's health or safety, but wa cause serious injury, impairment, was issued at an isolated scope (limited number of residents are a a limited number of staff are invosituation has occurred only occase.  The findings include:  The licensee's TB facility risk ass June 4, 2021, indicated they were RN-B's personnel file identified sl December 24, 2019. RN-B's personnel file identified sl December 24, 2019. RN-B's personnel file identified sl 2017, that was negative. The person oevidence a TB symptom screet testing was completed upon hire, days prior to the hire date.  On June 10, 2022, at 1:34 p.m. Resident was unaware she was required to symptom screening or TB testing because she had the TB quantified. The licensee's Tuberculosis Screedated August 1, 2021. identified will establish and maintain a com tuberculosis infection control progeto the most current tuberculosis in guidelines issued by the United Sfor Disease Control and Preventic Division of Tuberculosis Eliminati in the CDC's Morbidity and Morta Report (MMWR)."  "Staff whose essential job functio within the same air space of hom will be screened and tested for tuto the staff being exposed to clier	or death), and when one or a ffected or one or ved, or the ionally).  essment dated a low risk.  he was hired on sonnel file had a sted January 19, sonnel file had ening or any or within 90  IN-B stated she have a upon hire ron in the past.  ening policy [The licensee] prehensive gram according infection control tates Centers on (CDC), on, as published lity Weekly  ms require work e care clients berculosis prior	0 660				

Minnesota Department of Health

STATE FORM 5899 ZQBT11 If continuation sheet 24 of 105

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  ### TALLS LANDING ASSISTED LIVING  ### TALLS LANDING ASSISTED LIVING  ### TALLS LANDING ASSISTED LIVING  ### PIPESTONE, MN 56164    CALLS LANDING ASSISTED LIVING    CALLS LANDING ASSISTED LIVING    PREFIX   REGULATORY OR LISC IDENTIFYING INFORMATION)   PREFIX   REGULATORY OR LISC IDENTIFYING INFORMATION   PREFIX   PREFIX   PROFIX   PREFIX   PROFIX   PROFIX   PREFIX   PROFIX   PREFIX   PROFIX   PRO	AND DI AN OF CODDECTION INDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
### PALLS LANDING ASSISTED LIVING ### PRESTONE, MN 56164    (X4) ID   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX TAG   PRE	30347		B. WING		06/10/2022			
CALL   DEFICIENCY   DEFICIENCY   SUMMARY STATEMENT OF DEFICIENCIES   CACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DAFFE DAFF.   CACH DEFICIENCY   DEFICIENCY   DEFICIENCY	NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ADDRESS, CITY, STATE, ZIP CODE				
PRÉEFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  0 660  Continued From page 24  (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows:  1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs.  2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs.  3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented.  4. Staff TB screening results will be kept in each employee medical file.  5. Staff should be screened for signs and symptoms on an annual basis."  The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the	FALLS L	FALLS LANDING ASSISTED LIVING						
(annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows:  1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs.  2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs.  3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented.  4. Staff TB screening results will be kept in each employee medical file. 5. Staff should be screened for signs and symptoms on an annual basis."  The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the	PRÉFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE	
No further information was provided.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660	(annual) screening increased occupation Screening will be continued to the screening that some staff will be the work involves stresidents until the number of the screening that some staff will be the work involves stresidents until the number of the screening that some staff will be the work involves stresidents until the number of the screening that screening the screening that screening should be some starts working with screening should starts with screening should starts working with screening should starts working starts working st	will only be required with onal risk or exposure. Inducted as follows: e screened for active signs of ine TB HCWs. ave an IGRA blood test or a conducted with results are Baseline TB Screening Tool permitted to begin work where haring the air space with negative results of the first and documented or a negative sult is received and ning results will be kept in each file.  screened for signs and ninual basis."  Deartment of Health (MDH) ions for Tuberculosis Control on Care Settings, dated July on CDC guidelines, indicated an in working with patients after a rand symptom screen (no a TB disease) and a negative test) or TST (first step) dated are hire. The second TST may the HCW (health care worker) patients. Baseline TB e documented in the "	0 660				

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AND DI AN OF CORRECTION . IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	30347		B. WING		06/10/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
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PIPESTO		NE, MN 5610	64			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
0 680	Continued From pa	ge 25	0 680			
0 680 SS=F			0 680			
	(a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.  This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and have available a written emergency disaster plan with all required content outlined in Appendix Z. This had the potential to affect all current residents,					

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1101 NORTH HIAWATHA AVENUE PIPESTONE, MN 56164  (KA) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  O 680  Continued From page 26  This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).  The findings include:  The licensee's Disaster Planning and Emergency Preparedness binder, undated, included general policies for various threats and a hazard risk assessment, which included threats such as fire, severe weather, flooding, bomb threat. The binder lacked an assessment of the at risk population's needs.  The facility's plan lacked the following required content:  -an assessment of the at risk population's needs; - a comprehensive program to include infectious diseases; - a description of the population served by the	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
### FALLS LANDING ASSISTED LIVING ### PIPESTONE, MN 56164    (X4) ID PREFIX (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   DEPICIENCE (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   DEPICE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    0 680   Continued From page 26   Depiciency of the continued		30347		B. WING		06/·	10/2022
PIPESTONE, MN 56164  (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  0 680 Continued From page 26  This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).  The findings include:  The licensee's Disaster Planning and Emergency Preparedness binder, undated, included general policies for various threats and a hazard risk assessment, which included threats such as fire, severe weather, flooding, bomb threat. The binder lacked an assessment of the at risk population's needs.  The facility's plan lacked the following required content:  -an assessment of the at risk population's needs; - a comprehensive program to include infectious diseases;	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  0 680  Continued From page 26  This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but had the potential to have harmed a resident's health or safety but had sessued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).  The findings include:  The licensee's Disaster Planning and Emergency Preparedness binder, undated, included general policies for various threats and a hazard risk assessment, which included threats such as fire, severe weather, flooding, bomb threat. The binder lacked an assessment of the at risk population's needs.  The facility's plan lacked the following required content:  -an assessment of the at risk population's needs; - a comprehensive program to include infectious diseases;	FALLS LANDING ASSISTED LIVING						
This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).  The findings include:  The licensee's Disaster Planning and Emergency Preparedness binder, undated, included general policies for various threats and a hazard risk assessment, which included threats such as fire, severe weather, flooding, bomb threat. The binder lacked an assessment of the at risk population's needs.  The facility's plan lacked the following required content:  -an assessment of the at risk population's needs; - a comprehensive program to include infectious diseases;	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	COMPLETE
licensee; - process for emergency preparedness (EP) collaboration with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situations; - development of policies/procedures to address: - evacuation plan; - shelter in place; - the medical record documentation system to preserve resident information; - use of volunteers;	0 680	This practice results violation that did no safety but had the president's health or cause serious injury was issued at a wide problems are pervaluated failure that has affer a large portion or all. The findings included The licensee's Disa Preparedness binder policies for various assessment, which severe weather, flood binder lacked an asterior population's needs.  The facility's plan lacontent:  -an assessment of a comprehensive diseases;  - a description of the licensee;  - process for emergical abordance of the licensee of the collaboration with strong officials/organization of the licensee of the collaboration with strong officials organization of the licensee of the collaboration with strong officials organization of the licensee of the collaboration with strong officials organization of the licensee of the collaboration with strong of the license of the lic	ed in a level two violation (a tharm a resident's health or obtential to have harmed a safety, but was not likely to y, impairment, or death), and espread scope (when sive or represent a systemic cted or has potential to affect I of the residents).  E:  ster Planning and Emergency er, undated, included general threats and a hazard risk included threats such as fire, oding, bomb threat. The issessment of the at risk esessment of the at risk esessment of the infectious e population served by the gency preparedness (EP) tate and local EP ins; king staff and residents; is for staff and residents during ins; esession; esecond documentation system to information;	0 680			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/10/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 680	treatment at alternal - a communication - arrangement or - names and comphysicians; - contact inform local EP staff, or the original and local eragencies; - a method of semedical documental occupancy; and occupancy; and occupancy; and occupancy; and occupancy; and occupancy; and occupancy plan with experimentation of tremergency plan with experimentation of treme	ole in providing care and ative sites. plan that included: with other facilities; ontact information for resident ation for federal, state, tribal, e ombudsman; Iternative means for a facility staff, or federal, state, emergency management a haring information and ation for residents; ovide information regarding and its ability to provide the information about their aring information from the th residents and their families.	0 680			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	30347		B. WING		06/10/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FALLS LA	FALLS LANDING ASSISTED LIVING PIPESTO			HA AVENUE 64		
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0 700	Continued From pa	ge 28	0 700			
	144G.43 Subdivisio	n 1 Resident record	0 700			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	30347		B. WING		06/10/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
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(VA) ID	CHMMADV CTA		NE, MN 5610		ON.	(VE)
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0 700	Continued From pa	ge 29	0 700			
	observed a laptop s resident information medication for R2, went down the hall failed to lock the lap away, and it was vis and visitors.	t 6:30 a.m. the surveyor screen to be unlocked with a visible. ULP-D prepared locked the medication cart and way to R8's apartment. ULP-D otop screen prior to walking sible to other residents, staff,				
	medication for R2, locked the medication cart and went down the hallway to R2's apartment. ULP-E failed to lock the laptop screen prior to walking away. The laptop screen contained information including resident name and medications she was receiving. Housekeeping and kitchen staff were in the area of the medication cart upon ULP-E's return. At 9:13 a.m., ULP-E prepared medications for R6, locked the medication cart and went down the hallway to R6's apartment. ULP-E failed to lock the laptop screen prior to walking away. The laptop screen contained information including resident name and medications she was receiving. At approximately 9:15 a.m., ULP-E prepared medications for R8, locked the medication cart and went down the hallway to R8's apartment. ULP-E failed to lock the laptop screen prior to walking away. The laptop screen contained information including the names of all the residents. With each occurrence, the computer screen was visible to other residents, staff and visitors.  On June 7, 2022, at 9:26 a.m. registered nurse (RN)-B stated staff were to lock the laptop screen when walking away from the medication cart so that is not visible to other staff, residents, and visitors.					
	The licensee's police	cy Resident record -				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	30347		B. WING		06/1	0/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
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			NE, MN 5610			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
0 700	Continued From pa	ge 30	0 700			
	2021, identified "Re	ntent policy dated August 1, sident records whether written protected against loss, chorized disclosure."				
	No further informati	on was provided.				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-one				
0 780 SS=F	144G.45 Subd. 2 (a physical environme	) (1) Fire protection and nt	0 780			
		iving facility must comply with in Minnesota Rules, chapter				
	the State Fire Code  (i) provide smooth for sleeping purpose (ii) provide smooth separate sleeping at of bedrooms;  (iii) provide smooth separate sleeping at of bedrooms;  (iii) provide smooth smooth including crawl states (iv) where more required within an ir sleeping unit, interconthat actuation of one the individual dwelliful operate; and  (v) ensure the smoke alarms compexcept that newly in existing buildings medical smooth smoo	oke alarms in each room used				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	30347		B. WING		06/1	0/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
FALLS L	ANDING ASSISTED L	IVING	TH HIAWAT NE, MN 561	HA AVENUE 64			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
0 780	failed provide smoke throughout the facily had the ability to affect the facily had the ability to affect the facily had the ability to affect the facility to	ion and interview, the licensee to alarms in all sleeping rooms lity. This deficient condition fect all staff and residents.  ed in a level two violation (a st harm a resident's health or cotential to have harmed a safety, but was not likely to y, impairment, or death), and despread scope (when asive or represent a systemic acted or has potential to affect ll of the residents).	0 780				
0 810 SS=F		o)-(f) Fire protection and ent	0 810				
	maintain fire safety plans shall include (1) location and n rooms; (2) employee acti a fire or similar emo	living facility shall develop and and evacuation plans. The but are not limited to: number of resident sleeping fons to be taken in the event of ergency; procedures necessary for					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/	10/2022
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	NE, MN 5610			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
0 810	evacuation, or relocemergency including or unusual resident evacuation.  (c) Employees of a receive training on plans upon hiring a thereafter.  (d) Fire safety and readily available at (e) Residents who at their own evacuation proper actions to tainclude movement, training shall be maleast once per year (f) Evacuation drills twice per year per sevacuation drill ever the residents is not	r resident movement, cation during a fire or similar of the identification of unique needs for movement or essisted living facilities shall the fire safety and evacuation at least twice per year evacuation plans shall be all times within the facility, are capable of assisting in on shall be trained on the like in the event of a fire to evacuation, or relocation. The lade available to residents at	0 810			
	This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements. This had the potential to affect all staff, residents, and visitors.					
	violation that did no safety but had the p resident 's health or cause serious injury was issued at a wid	ed in a level two violation (a ot harm a resident's health or cotential to have harmed a r safety, but was not likely to y, impairment, or death), and despread scope (when asive or represent a systemic				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		30347	B. WING		06/	06/10/2022	
	PROVIDER OR SUPPLIER  ANDING ASSISTED L	IVING 1101 NOI	DDRESS, CITY, S RTH HIAWATH NE, MN 5616				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
0 810	failure that has affe a large portion or all Findings include:  A record review and May 17, 2022, at ap Licensed Assisted I Maintenance (M)-1 devacuation plan, first training, and evacuation plan, first training, and evacuations to be taken emergency. During that the fire safety a facility lacked these Record review of the indicated that the licent protection procedure included in the fire suburing interview, LA safety and evacuations.  Record review of the indicated that the fire suburing interview, LA safety and evacuations.  Record review of the indicated that the fired in the suburing interview of the indicated that the fired in the suburing interview of the indicated that the fired in the suburing interview of the indicated that the fired in the suburing interview of the indicated that the fired in the suburing interview of the indicated that the fired in the suburing interview of the indicated that the fired in the suburing interview of the indicated that the fired in the suburing interview of the indicated that the fired in the suburing interview of the indicated that the fired in the suburing interview of the indicated that the fired in the suburing interview of the indicated that the fired in the suburing interview of the indicated that the fired indicated that the fired indicated that the fired indicated that the fired indicated that the suburing interview in the	cted or has potential to affect all of the residents).  d interview were conducted on opproximately 9:50 a.m. with Living Director (LALD)-A and on the fire safety and e safety and evacuation ation drills for the facility.  The available documentation censee did not have employee in the event of a fire or similar interview, LALD-A indicated and evacuation plan for the exprovisions.  The available documentation censee did not have fire exprovisions.  The available documentation censee did not have fire exprovisions.  The available documentation censee did not have fire expressed in the facility lacked and evacuation plan.  ALD-A indicated that the fire ion plan for the facility lacked are available documentation re safety and evacuation plan.	0 810				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		30347	B. WING		06/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1101 NOR	TH HIAWATI	HA AVENUE		
FALLS L	ANDING ASSISTED L	IVING PIPESTOI	NE, MN 561	64		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01370 SS=F		a) Training and evaluation of	01370			
	unlicensed personn (1) documentation is provided; (2) reports of change to the supervisor de (3) basic infection of pathogens; (4) maintenance of environment; (5) appropriate and hygiene and groom (i) hair care and base (ii) care of teeth, guidevices; (iii) care and use of (iv) dressing and as (6) training on the p (7) standby assistant perform them; (8) medication, exe reminders; (9) basic nutrition, r and assistance with (10) preparation of licensed health prof (11) communication the dignity of the re- the resident and the cultural background (12) awareness of o (13) understanding between staff and r family;	safe techniques in personal ing, including: thing; ims, and oral prosthetic  Thearing aids; and esisting with toileting; orevention of falls; ince techniques and how to rcise, and treatment  meal preparation, food safety, in eating; modified diets as ordered by a fessional; in skills that include preserving sident and showing respect for the resident's preferences, it, and family; confidentiality and privacy; appropriate boundaries esidents and the resident's use in handling various				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/	10/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWATI NE, MN 5610	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
01370	(15) awareness of of technology equipmed. This MN Requiremed by: Based on observation review, the licensed unlicensed personned completed training a in all required training a in all required training. This practice results violation that did not safety but had the president's health or widespread scope (or represent a system or has the potential of the residents).  The findings included ULP-C was hired or direct care and services under the license. ULP-C beg services under the license. ULP-C beg services under the license. ULP-C exited R1's at the shower.  On June 6, 2022, at ull and the license of the residents under the license. On June 6, 2022, at ull and the license of the license o	commonly used health ent and assistive devices.  ent is not met as evidenced on, interview, and record efailed to ensure two of two rel (ULP)-C and ULP-D) and competency evaluations ng topics.  ed in a level two violation (at harm a resident's health or obtential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all es:  In March 23, 2021, to provide vices to the licensee's comprehensive home care an providing direct care and assisted living licensure on a tapproximately 11:10 a.m. apartment after assisting him at 11:13 a.m. ULP-C stated she ther ULP on how to administer urse did not train or a medication administration tasks.				
	On June 6, 2022, a	t 11:16 a.m. ULP-C was				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		30347	B. WING		06/1	0/2022
NAME OF PROVIDE	R OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FALLS LANDIN	G ASSISTED L	IVING	RTH HIAWATI NE, MN 5610			
	EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
obser 11:50  ULP-(comp follow -approhygiet -hair of care -care -dress -stand performation of the composition	a.m. she adm C's employee etency testing ring required to opriate and sa ne and groom care and bath of teeth, gum and use of he sing and assis dby assistance rm them.  D was hired o care and servents under the se. ULP-D beg es under the st 1, 2021.  une 7, 2022, a rved administe une 7, 2022, a rved admini	ering medication to R2, and at ninistered medication to R4.  record lacked evidence was completed on the opics:  afe techniques in personal ing, including:	01370			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/	10/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
FALLS	LANDING ASSISTED L	IVING	TH HIAWATH			
	OUR MAN ENVIOLE		NE, MN 5616			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
01370	perform them; -medication, exercis -communication ski dignity of the reside resident and residents -awareness of conf -understanding app staff and residents -procedures to use emergency situation  In addition, ULP-D's evidence competent the following require -standby assistance perform them.  On June 6, 2022, a was working on form she had not implem completed the onlin Then, they followed and then they were other ULP observint allowed to pass me delegated tasks ind available to answer would observe staff formal training or co by the RN.  The licensee's Com policy, dated Augus registered nurse or staff of [the facility] delegation of service unlicensed personn	se, and treatment reminders; ills that include preserving the ent and showing respect for the sident's preferences, cultural mily; identiality and privacy; ropriate boundaries between and the resident's family; in handling various as; seemployee record lacked acy testing was completed on	01370			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	30347		B. WING		06/1	0/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EALLOI	ANDING ASSISTED I	NAME 1101 NOR	TH HIAWATI	HA AVENUE		
FALLS L	ANDING ASSISTED L	PIPESTON	NE, MN 5610	64		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
01370	Continued From pa	ge 38	01370			
01370	to competently follothe tasks."  "1. A Registered Nuprofessional where what nursing service properly trained and unlicensed personn 2. Only unlicensed to be competent an skills consistent with being delegated will delegated tasks.  3. The Assisted Livin place to communa RN regarding currompetencies.  4. Training and comwill be conducted be may provide the trace.  5. Training and comwill be conducted be may provide the trace.  5. Training and comwill be conducted be may provide the trace.  6. Training and comwill be conducted be may provide the trace.  7. Training and comwill be conducted be may provide the trace.  8. Training and comwill be conducted be may provide the trace.  9. Appropriate and the personal hygiene and in hair care.  10. Appropriate and in the care of teaching the care of the care of teaching the ca	w the procedures and perform arse (or other licensed health appropriate) will determine es may be delegated to decompetency tested arel.  personnel who are determined depossess the knowledge and the complexity of tasks. If the permitted to perform such and facility will have a system are a	01370			
	f) Training on th	ne prevention of falls istance techniques and how to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/	10/2022
	PROVIDER OR SUPPLIER  ANDING ASSISTED L	IVING 1101 NOI	DDRESS, CITY, S RTH HIAWATH NE, MN 5616			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
01370	reminders i) Basic nutrition safety, and assistan j) Preparation of a licensed health procedures to the respect for the respec	exercise, and treatment  n, meal preparation, food nce with eating of modified diets as ordered by rofessional cion skills that include ity of the resident and showing cident and the resident's al nd family f confidentiality and privacy ing appropriate boundaries esidents and the resident's to use in handling various ns of commonly used health ent and assistive devices."	01370			
01380 SS=F	unlicensed personn  (b) In addition to paragraphic competency evaluated providing assisted I (1) observing, reported that the status;  (2) basic knowledged changes in body fur observed changes appropriate personners.	ragraph (a), training and tion for unlicensed personnel iving services must include: rting, and documenting e of body functioning and nctioning, injuries, or other that must be reported to nel; ording temperature, pulse,	01380			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	30347		B. WING		06/1	0/2022
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00.	0.202
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWATI NE, MN 5610			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
01380	(4) recognizing phy and developmental (5) safe transfer ted (6) range of motion (7) administering management (7) administering management (8) required.  This MN Requirement (8) Based on observation of the resident of the r	sical, emotional, cognitive, needs of the resident; chniques and ambulation; ing and positioning; and ledications or treatments as ent is not met as evidenced ion, interview, and record a failed to ensure two of two nel (ULP)-C and ULP-D and competency evaluations ng topics.  ed in a level two violation (a st harm a resident's health or potential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all e:  In March 23, 2021, to provide vices to the licensee's a comprehensive home care pan providing direct care and assisted living licensure on the approximately 11:10 a.m. apartment after assisting him	01380			
	was trained by anot	ther ULP on how to administer urse did not train or				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30347	B. WING		06/1	0/2022
	PROVIDER OR SUPPLIER  ANDING ASSISTED L	IVING 1101 NOR		STATE, ZIP CODE HA AVENUE 64		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
01380	competency test he or other delegated to or other delegated to On June 6, 2022, a observed administed 11:50 a.m. she adm ULP-C's employee competency testing following required to appropriate and sa hygiene and groom reading and record respirations of the recognizing physic developmental needsafe transfer technarange of motioning administering med required; blood glucose morninsulin administrati ULP-D ULP-D was hired or direct care and services under the license. ULP-D beg services under the license. ULP-D beg services under the lobserved administed On June 7, 2022, arobserved administed On June 7, 2022, arobserved administed On June 7, 2022, arobserved glood	er on medication administration casks.  It 11:16 a.m. ULP-C was ering medication to R2, and at hinistered medication to R4.  record lacked evidence was completed on the opics: fe techniques in personal ing, including: ling temperature, pulse, and esident; al, emotional, cognitive, and ds of the resident; iques and ambulation; and positioning; ications or treatments as	01380			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	30347		B. WING		06/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	TH HIAWATI			
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	NE, MN 5610	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
01380	Continued From page 42		01380			
	training was completopics: -observing, reporting status; -basic knowledge of changes in body fur observed changes appropriate persongrecognizing physic developmental need-blood glucose moreapplying braces.  In addition, ULP-D's evidence competer the following requires	al, emotional, cognitive, and ds of the resident; nitoring; and s employee record lacked ncy testing was completed on ed topics: ding temperature, pulse, and resident;				
	On June 6, 2022, at 3:52 p.m. RN-B stated she was working on forms for competency testing, but she had not implemented that yet. New staff completed the online training and tested on that. Then they followed other ULP for a couple days. They were then allowed to pass medications with another ULP observing them. Staff were then allowed to pass medications and perform other delegated tasks independently. RN-B was available to answer questions and occasionally would observe staff. She confirmed there was no formal training or competency testing completed by the RN.  The licensee's Competency Training Evaluations policy, dated August 1, 2021, identified "When a registered nurse or licensed health professional					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.	A. BUILDING.		
		30347	B. WING		06/	10/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	ORTH HIAWAT ONE, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
01380	staff of [the facility] delegation of service unlicensed personnethods to performeach client and are to competently following the tasks."  "1. A Registered Nuprofessional where what nursing service properly trained and unlicensed personned. Only unlicensed to be competent and skills consistent with being delegated will delegated tasks.  3. The Assisted Livin place to communate RN regarding curcompetencies.  4. Training and communate and competencies.  4. Training and communate in training and competencies will be conducted be may provide the training and competencies must incluate a. Observing, resident status b. Basic knowled changes in body furobserved changes appropriate personate. Reading and and respirations of d. Recognizing and developmental e. Safe transfer f. Range of more	delegates tasks, prior to the ces they must make certain the proper in the tasks or procedures for able to demonstrate the abilition with appropriate) will determine the appropriate) will determine the may be delegated to dompetency tested in the complexity of tasks and perform such the complexity of tasks are the personnel who are determined to possess the knowledge and the permitted to perform such the complexity of tasks are the permitted to perform such the complexity of tasks are the permitted to perform such the complexity of tasks are the permitted to perform such the permitted in peternial performance of ULP's performing in conjunction with a RN performance of body functioning and inctioning, injuries, or other that must be reported to nell precording temperature, pulse the properties of the providing temperature, pulse the properties of the providing temperature, pulse the properties and the properties of the providing temperature, pulse the properties the properties of the properties that must be reported to nell processing temperature, pulse the properties that the properties that the properties that the properties that the properties of the properties that	y n dd d			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30347	B. WING		06/10/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWATI NE, MN 5610			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01380	Continued From pa	ge 44	01380			
	as required"					
	No further information was provided.					
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-one				
01440 SS=F	144G.62 Subd. 4 S delegated nurs	upervision of staff providing	01440			
	therapy tasks must appropriate licenseregistered nurse act facility's policy when provided to verify the performed competer and solutions related to perform the tasks performing medicated administration shall nurse or appropriate and must include of administering the minteraction with the (b) The direct superdelegated tasks much calendar days after individual begins we performs the delegated requirement also apperformed delegated. This MN Requirement by:  Based on observation review, the licenseed	be provided by a registered e licensed health professional bservation of the staff nedication or treatment and the				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/1	0/2022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	TH HIAWATI NE, MN 5610			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01440	supervision of staff or therapy tasks wit those services for opersonnel (ULP)-Freviewed.  This practice results violation that did no safety but had the president's health or widespread scope (or represent a syste or has the potential of the residents).  The findings include ULP-C ULP-C was hired or direct care and servesidents under the license. ULP-C beg services under the August 1, 2021.  On June 6, 2022, a ULP-C exited R1's to shower.  On June 6, 2022, a observed administed 11:50 a.m. she administed on June 8, 2022, a observed supervising and insulin administrations.	performing delegated nursing thin 30 days of first providing one of two unlicensed with employee records  ed in a level two violation (a tharm a resident's health or potential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all exices to the licensee's comprehensive home care an providing direct care and assisted living licensure on a tapproximately 11:10 a.m. apartment after assisting him apartment after assisting him a tapproximately 11:10 a.m. apartment after assisting him a tapproximately 11:10 a.m. apartment after assisting him apartment after assisting him apartment after assisting him apartment after assisting him a tapproximately 11:10 a.m. apartment after assisting him apartment	01440			
	supervision had bee	en performed by a RN.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3)			X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/1	0/2022
	PROVIDER OR SUPPLIER  ANDING ASSISTED L	IVING 1101 NOF	DRESS, CITY, S TH HIAWATI NE, MN 5610			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01440	ULP-D ULP-D was hired or direct care and serv residents under the license. ULP-D beg services under the August 1, 2021.  On June 7, 2022, a observed administed on June 7, 2022, a ULP-D was observed performing blood gl braces to bilateral k getting dressed.  ULP-D's employee supervision had been comp visits. She was una The licensee's Supervices policy date "direct supervision tasks must be provafter the date on whorking for Falls Laperforms the delegathereafter as needed.	in June 11, 2018, to provide vices to the licensee's comprehensive home care an providing direct care and assisted living licensure on at 6:30 a.m. ULP-D was bring eye drops to R4.  It approximately 6:40 a.m. and administering medications, ucose monitoring, applying thees, and assisting R8 with a file lacked evidence a 30 day an performed by a RN.  In at 10:51 a.m. RN-B stated she leting 30 day supervisory ware of the requirement.  It approximately 6:40 a.m. are a supervisory and assisting R8 with a supervisory and assisting R8 with a supervisory ware of the requirement.  In a supervisory ware of the requirement and a supervisor and a superviso	01440			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30347	B. WING		06/10/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWATI NE, MN 5616			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
01470	Continued From page 47		01470			
01470 SS=F			01470			
	topics: (1) an overview of t (2) an introduction a policies and proced of assisted living se person; (3) handling of eme emergency services (4) compliance with maltreatment of vul 626.557 to the Minr Center (MAARC); (5) the assisted livir responsibilities rela and protection of th (6) the principles of and service delivery support services pr (7) handling of resic complaints, and wh including information Facility Complaints; (8) consumer advoc Ombudsman for Lo Ombudsman for Lo Ombudsman at the Services, county-m other relevant advo (9) a review of the t services the employ facility's category of (b) In addition to the orientation may also	and review of the facility's ures related to the provision ervices by the individual staff regencies and use of s; and reporting of the nerable adults under section nesota Adult Abuse Reporting in gill of rights and staff ted to ensuring the exercise ose rights; person-centered planning and how they apply to direct ovided by the staff person; dents' complaints, reporting of ere to report complaints, in on the Office of Health cacy services of the Office of ing-Term Care, Office of ing-Term Care, Office of ing-Term Care, of Human in an an an adult in the cacy services; and in the individual individual in the individual indivi				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	` ′		COMPLETED	
	30347	B. WING		06/1	0/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
FALLS LANDING ASSISTED L	IVING	TH HIAWATI			
	PIPESTON	NE, MN 5610	64		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
01470 Continued From pa	ge 48	01470			
training on hearing subdivision must be based, may include include training on of topics:  (1) an explanation of and how it manifest the challenges it pood (2) health impacts of age-related hearing incidence of demensiolation, and depresionation, and depresionation, and depresionation, and tactile alerting of and tactile alerting of and tactile alerting of access in real time,  This MN Requirementations and tactile alerting of access in real time,  This MN Requirementation for three of personnel (ULP)-C, (RN)-B) with record this practice results of the president's health or widespread scope (or represent a systematical includes the president's health or widespread scope (or represent a systematical includes the president's president's president's systematical includes the president's pre	loss provided under this e high quality and research online training, and must one or more of the following of age-related hearing loss ts itself, its prevalence, and sees to communication; related to untreated gloss, such as increased hita, falls, hospitalizations, ession; or ut strategies and technology communication and ing communication strategies, levices, hearing aids, visual devices, communication and closed captions.  The service of the following of the following communication and ing communication strategies, levices, hearing aids, visual devices, communication and closed captions.  The service of the following of the following communication and ing communication and ing communication strategies, levices, hearing aids, visual devices, communication to assisted and record review, the insure orientation to assisted the included all the required three employees (unlicensed three employees (unlicensed three employees) (unlice				

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Minnesota Department of Health STATE FORM

ULP-C. ULP-D, and RN-B's employee files lacked

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/10/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	TH HIAWATI			
		PIPESTON	NE, MN 5610			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01470	Continued From page 49		01470			
	topics as required, living services on A - an overview of As: - an introduction an policies and proced assisted living serviperson; - the assisted living responsibilities rela and protection of th - the principles of preservice delivery and support services preservices on A - the principles of preservices preservices preservices on A - an overview of Assistance of	sisted Living statutes 144G; d review of the facility's ures related to the provision of ces by the individual staff bill of rights and staff ted to ensuring the exercise				
	ULP-C ULP-C was hired on March 23, 2021, to provide direct care and services under the comprehensive home care licence. She began providing direct care and services under the assisted living license beginning August 1, 2021.					
		t approximately 11:10 a.m. apartment after assisting him				
	On June 6, 2022, at 11:16 a.m. ULP-C was observed administering medication to R7, and at 11:50 a.m. she administered medication to R4.  On June 8, 2022, at 6:41 a.m. ULP-C was observed supervising blood glucose monitoring and insulin administration for R5.					
	following training: -Guide to Assisted I which included an o statutes 144G and	ntified she had completed the Living - MN on April 6, 2022, overview of Assisted Living an introduction and review of and procedures related to the				

Minnesota Department of Health

STATE FORM 5899 ZQBT11 If continuation sheet 50 of 105

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1101 NORTH HIAWATHA AVENUE PIPESTONE, MN 56164  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  01470  Continued From page 50 provision of assisted living services by the individual staff person; -Assisted Living Bill of Rights on March 29, 2022; and -Person Centered Care Principles on May 4, 2022.  Although there was evidence training was completed, it was not completed prior to providing assisted living services under the comprehensive home care licence. She began providing direct care and services under the assisted living license beginning August 1, 2021.		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
TALLS LANDING ASSISTED LIVING    Continued From page 50   Prevision of assisted living services by the individual staff person; -Assisted Living Bill of Rights on March 29, 2022; and -Person Centered Care Principles on May 4, 2022.   Although there was evidence training was completed, it was not completed prior to providing assisted living services under the comprehensive home care licence. She began providing direct care and services under the			30347	B. WING		06/1	0/2022
PIPESTONE, MN 56164  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  01470  Continued From page 50  provision of assisted living services by the individual staff person; -Assisted Living Bill of Rights on March 29, 2022; and -Person Centered Care Principles on May 4, 2022.  Although there was evidence training was completed, it was not completed prior to providing assisted living services on August 1, 2021.  ULP-D  ULP-D was hired on June 11, 2018, to provide direct care and services under the comprehensive home care licence. She began providing direct care and services under the	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  O1470  Continued From page 50  provision of assisted living services by the individual staff person; -Assisted Living Bill of Rights on March 29, 2022; and -Person Centered Care Principles on May 4, 2022. Although there was evidence training was completed, it was not completed prior to providing assisted living services on August 1, 2021.  ULP-D  ULP-D was hired on June 11, 2018, to provide direct care and services under the comprehensive home care licence. She began providing direct care and services under the	FALLS L	ANDING ASSISTED L	IVING				
provision of assisted living services by the individual staff person; -Assisted Living Bill of Rights on March 29, 2022; and -Person Centered Care Principles on May 4, 2022. Although there was evidence training was completed, it was not completed prior to providing assisted living services on August 1, 2021.  ULP-D ULP-D was hired on June 11, 2018, to provide direct care and services under the comprehensive home care licence. She began providing direct care and services under the	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUNDS) CROSS-REFERENCED TO THE APPROPRIES	JLD BE	COMPLETE
On June 7, 2022, at 6:30 a.m. ULP-D was observed administering eye drops to R4.  On June 7, 2022, at approximately 6:40 a.m. ULP-D was observed administering medications, performing blood glucose monitoring, applying braces to bilateral knees, and assisting R8 with getting dressed.  ULP-D's record identified she had completed the following training: -Assisted Living Bill of Rights on December 13, 2021; and -Person Centered Care Principles on December 31, 2021.  ULP-D's record lacked evidence she had completed the following: - an overview of Assisted Living statutes 144G; and - an introduction and review of the facility's policies and procedures related to the provision of	01470	provision of assiste individual staff pers-Assisted Living Bill and -Person Centered (2022. Although there was completed, it was nassisted living serv ULP-D ULP-D was hired ordirect care and serv comprehensive hor providing direct care assisted living licen On June 7, 2022, a observed administed On June 7, 2022, a observed administed On June 7, 2022, a observed administed ULP-D's record ide following training: -Assisted Living Bill 2021; and -Person Centered (31, 2021. ULP-D's record laccompleted the follor an overview of As and - an introduction and	d living services by the on; I of Rights on March 29, 2022; Care Principles on May 4, I evidence training was not completed prior to providing ices on August 1, 2021.  In June 11, 2018, to provide vices under the me care licence. She began e and services under the se beginning August 1, 2021.  It 6:30 a.m. ULP-D was being eye drops to R4.  It approximately 6:40 a.m. ed administering medications, lucose monitoring, applying tenes, and assisting R8 with assisting R8 with a lof Rights on December 13, Care Principles on December where the lof Rights on December 14 december 14 december 14 december 15 december 15 december 16 december 16 december 17 december 17 december 18 december 19 dec				

Minnesota Department of Health

STATE FORM 56899 ZQBT11 If continuation sheet 51 of 105

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/10/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	TH HIAWATI NE, MN 5610			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICENCY)	D BE	(X5) COMPLETE DATE
01470	- Francisco Page 5		01470			
	person.					
	provide direct care comprehensive hor providing direct care assisted living licen RN-B's record identifollowing training:	December 24, 2019, to and services under the ne care licence. She began e and services under the se beginning August 1, 2021. tified she had completed the of Rights on November 11,				
	RN-B's record lacked evidence she had completed the following: - an overview of Assisted Living statutes 144G; and - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.					
	assisted living direct online training record completed since as August 1, 2021. She completed prior had assigned it on the complete on the complete of the co	at 12:45 p.m. licensed stor (LALD)-A confirmed the rds was the only training sisted living licensure on the was unaware it needed to to August 1, 2021, and she the online training system to staff's annual training.				
	No further informati	on was provided.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		30347	B. WING	· · · · · · · · · · · · · · · · · · ·	06/1	0/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
FALLS L	ANDING ASSISTED L	IVING		HA AVENUE			
	011111111111111111111111111111111111111		NE, MN 5610				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE	
01530	Continued From pa	ge 52	01530				
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED		01530				
	following training re (1) supervisors of d least eight hours of specified under parthours of the employ have at least two horelated to dementia employment therea (2) direct-care employ at least eight hours specified under parthours of the employ initial training is conprovide direct care employee on site weight hours of trainidementia care and and assist if issues requirements under meeting the require available for consuluntil the training reconcept of training on each 12 months of  This MN Requirements of the months of the employees (ULP-D and register required amount of	irect-care staff must have at initial training on topics agraph (b) within 120 working ment start date, and must ours of training on topics care for each 12 months of fter; loyees must have completed of initial training on topics agraph (b) within 160 working ment start date. Until this applete, an employee must not unless there is another the has completed the initial and on topics related to who can act as a resource arise. A trainer of the paragraph (b) or a supervisor ments in clause (1) must be tation with the new employee puirement is complete. The sees must have at least two topics related to dementia for employment thereafter; the is not met as evidenced on, interview and record of failed to ensure three of an onlicensed personnel (ULP)-C, ed nurse (RN)-B) received the dementia care training, in the erin accordance with 144G.64					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/10/2022	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVIN( <del>i</del>	NE, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01530	0 Continued From page 53		01530			
	violation that did no safety but had the president's health or pattern scope (whe of residents are affenumber of staff are occurred repeatedly pervasive).  The findings included The licensee provided living license.  During the entrance at approximately 9: living director (LALIC (RN)-B stated the license of demendance of the license o	ed in a level two violation (a tharm a resident's health or potential to have harmed a safety) and was issued at a more than a limited number ected, more than a limited involved, or the situation has y; but is not found to be eccentrated as an assisted ecconference on June 6, 2022, 18 a.m., licensed assisted eccensee had residents with the tia, but had no special care ding services under the ne care license on March 23, roviding services under the sure on August 1, 2021.				
	ULP-C had received training on March 1	record contained evidence d five hours dementia related 6, 2021, and 2.5 hours of 2. ULP-C lacked the required training.				
	through 11:50 a.m.	2, at approximately 10:50 a.m. ULP-C was observed nd administering medications				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	30347		B. WING		06/1	0/2022
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	TH HIAWATI NE, MN 5610	HA AVENUE 64		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01530	ULP-D ULP-D began provice comprehensive hor 2018, and began provises a sisted living licen.  ULP-D's employee ULP-D had received training on December training on December training on December training on December the required eight horough 6:45 a.m. Used training medicand assisting a resistant and assisting a resistant living licen.  RN-B RN-B began provide comprehensive hor 24, 2019, and began assisted living licen.  RN-B's employee real RN-B had received training in January straining in November required eight hours.  On June 10, 2022, licensed assisted licensing the demonstration on line. LAND-A continued the demonstration on line. LAND-A continued the demonstration of	ding services under the ne care license on June 11, roviding services under the sure on August 1, 2021.  record contained evidence of three hours dementia related over 23, 2020, and 2.25 hours of over 14, 2021. ULP-D lacked ours of initial training.  pproximately 6:15 a.m.  JLP-D was observed cation, placing knee braces dent to get dressed.  Ing services under the ne care license on December n providing services under the sure on August 1, 2021.  Decord contained evidence 3.25 hours dementia related 2021, and 3.25 hours of er 2021. RN-B lacked the sof initial training.  Part approximately 12:45 p.m.  Pring director (LALD)-A centia training was completed on firmed the employees did an amount of training in LD-A stated with the new training was included in the training.	01530			
	No further informati	on was provided.				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30347	B. WING		06/10/2022	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	TH HIAWATI NE, MN 5610	HA AVENUE 64		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01530	Continued From page 55		01530			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days					
01620 SS=F			01620			
	be conducted no mafter initiation of ser reassessment and as needed based or resident and cannor from the last date of (d) For residents or services specified in 9, clauses (1) to (5) individualized initial and preferences. The completed within 30 services. Resident be conducted as new the needs of the rescalendar days from (e) A facility must in of the availability of long-term care consisted in 256B.0911, prospective resident facility or the date or resident moves in, where the services is the conducted of the resident moves in, where the conducted is the conducted as new the needs of the residendar days from (e) A facility must in of the availability of long-term care consistency in the date of the conducted in the conducted	ally receiving assisted living in section 144G.08, subdivision in the facility shall complete an review of the resident's needs the initial review must be colored and calendar days of the start of monitoring and review must seeded based on changes in sident and cannot exceed 90 the date of the last review. Form the prospective resident and contact information for sultation services under prior to the date on which a trexecutes a contract with a nowhich a prospective whichever is earlier.				
	by: Based on interview licensee failed to er assessments were residents (R5, R4, I to complete a change	and record review, the assure ongoing comprehensive completed timely for six of six R6, R7, R8 and R2), and failed ge in condition assessment resident (R2) with record				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED
	30347	B. WING		06/1	0/2022
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FALLS LANDING ASSISTED LIVING	ì	TH HIAWATI NE, MN 5610			
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	T BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
or represent a systemic or has the potential to affor of the residents).  The findings include:  R5 R5 was admitted on Jane R5's service plan dated a signed by the resident refacility staff. The service boxes to identify a descrete received, the identification provide the services, and methods of monitoring a none of the boxes were in R5's June 2022, medicate identified she received in by the facility staff three administration of Victozal medication.  R5's RN Baseline Assessing the residents of the services and medication.	a level two violation (am a resident's health or tial to have harmed a ty) and was issued at an problems are pervasive failure that has affected fect a large portion or all uary 15, 2022.  January 15, 2022, was expresentative and the plan contained check ciption of the services on of staff who will define the schedule and assessments; however, marked.  Ition administration record nedication administration times a day, including the a (diabetes) injectable  Issment was dated 14 Day Assessment was (16 days after)	01620			

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	AND DI AN OF CORRECTION INTERCATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		30347	B. WING		06/	10/2022
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWAT ONE, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
01620	R4 R4's service plan daidentified he received (thrombo embolic dand medication material R4's last 90 Day As 25, 2022. There has assessments compound on June 9th, 2022, there had been no a January 25, 2022.  R6 R6's service plan daidentified she received bathing, applying Theoretical March 1, 2022. The assessments compound further assessments compound further assessments compound further assessments after March 1, 2022.  R7 R7's service plan dashe received assist TED stockings, and R7's previous two 9 dated December 8, There were no furth after March 8, 2022.  On June 9, 2022, a	ated September 13, 2020, ed bathing, applying TED leterrent) stockings, dressing, nagement.  Seessment was dated January ad been no further pleted after January 25, 2022.  at 12:20 p.m. RN-B confirmer assessments completed after assessments completed after bedication management.  Seessment was completed ere were no further pleted after March 1, 2022.  at 12:22 p.m. RN-B confirmer pleted after March 1, 2022.  at 12:22 p.m. RN-B confirmer pleted after March 1, 2022.  at 12:23 p.m. RN-B confirmer pleted after March 1, 2022.  at 12:24 p.m. RN-B confirmer pleted after March 1, 2022.  at 2021, and March 8, 2022.  at 2021, and March 8, 2022.  are assessments completed				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		30347		B. WING		06/	10/2022
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING		TH HIAWATI NE, MN 5610			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
01620	Continued From pa	ge 58		01620			
	after March 8, 2022	2.					
	R8 R8's service plan didentified he receive blood glucose monimanagement.	ed assistance v	with bathing,				
	R8's last 90 Day As December 2, 2022, were no further ass March 1, 2022.	and March 1,	2022. There				
	On June 9, 2022, a further assessment March 1, 2022.						
	R2 R2's service plan dashe received assist dressing, applying management.	ance with with	bathing,				
	R2's last 90 Day As 2022.	sessment was	dated March 8,				
	On June 6, 2022, a medication adminis noted to have purpl entire left side of he noted under the left had a fall in the pastrying to get to her vision and the second seco	tration observate green discolor of face with sor teye. ULP-C ic of R2 stated th	ation, R2 was oration to the me swelling dentified she at she was				
	In addition, R2's fall unlicensed personn a fall on May 13, 20 of the fall indicated routines and had sawas trying to get up	nel (ULP)-D, ide 022, at 10:10 p "Staff was doin aw her sitting o	entified she had .m. Description ng bed check in the floor and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7 ti Boilebii (o.			
		30347	B. WING		06/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWATI NE, MN 5616			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01620	socket underneath information include to lower left cheek cm height. with son have small hemato  On June 9, 2022, a there have been not completed after Maher annual review I been completed.  On June 9, 2022, a formal assessment A fall with injury wo and a comprehensi indicated. The procure "huddle," but no for The licensee's Asse Monitoring policy dathe following:  "1. The initial nursir reassessment must the uniform assess conducted in perso writing, dated, and who conducted the 2. If necessitated bedistance between the facility, or urger circumstances, the conducted using te based on practice is resident's needs ar planning and care of 3. Resident reasses be conducted no mediate the same conducted on mediate conducted on mediate conducted on mediate conducted no mediate con	of her left eye." Injury d "Large hematoma sustained bone, approx 6 cm across 4 he protrusion, laceration. Does ma visible above eye."  It 9:52 a.m. RN-B confirmed further assessments inch 8, 2022. R2 was due for ast month but it had not yet  It 10:35 a.m. RN-B stated no swere completed after a fall. all be a change in condition inversessment would be ess after a fall included a mal assessment process.  It include all the elements of ment tool as required, in (unless see #2), be in signed by the registered nurse assessment. In the geographic interprospective resident and interprospective resident an	01620			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		30347	B. WING		06/	10/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWATI NE, MN 5616			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
01620	resident and canno from the last date on "6. The facility will of during a holiday, and who is ready to be of and return to the fath."  No further informations	n changes in the needs of the texceed 90 calendar days of the assessment." conduct a nursing assessment at the weekend for a resident discharged from the hospital cility."	01620			
01650 SS=E	and revisions to  (f) The service plant (1) a description of the fees for service service, according to assessment and re (2) the identification who will provide the (3) the schedule an assessments of the (4) the schedule an providing services; (5) a contingency p (i) the action to be to cannot be provided (ii) information and facility; (iii) the names and the resident wishes emergency or if the change in the resid identification of and	the services to be provided, s, and the frequency of each to the resident's current sident preferences; n of staff or categories of staff e services; d methods of monitoring e resident; d methods of monitoring staff and lan that includes: aken if the scheduled service	01650			

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/	10/2022	
	PROVIDER OR SUPPLIER  ANDING ASSISTED L	IVING 1101 NOF	DRESS, CITY, S' RTH HIAWATH NE, MN 5616				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
01650	(iv) the circumstant medical services ar consistent with cha declarations made chapters.  This MN Requirement by: Based on interview licensee failed to end the required content (R4, R5) with record.  This practice result violation that did not safety but had the president's health or cause serious injury was issued at a pat limited number of rethan a limited number of r	ces in which emergency re not to be summoned pters 145B and 145C, and by the resident under those ent is not met as evidenced and record review, the resure the service plan included at for two of three residents ds reviewed.  The service two violation (and tharm a resident's health or cotential to have harmed a safety, but was not likely to be an exident are affected, more correctly; but is not we harmed a safety, but was not likely to be an exident are affected, more correctly indicated the sure on August 1, 2021.  The service is in which emergency records the sure on August 1, 2020, and bathing, applying TED deterrent) stockings, dressing, nagement.	01650				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/	10/2022	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
FALLS I	ANDING ASSISTED L	IVING	RTH HIAWATI NE, MN 5616				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
01650	identify supervision tasks would be come R5 R5's service plan designed by the resident facility staff. The services of the identify a creceived, the identify provide the services of monitoring assess boxes were marked R5's June 2022, make identified she received by the facility staff the administration of Vinnedication. R5's 90 Day Assess identified she received management, and long June 9, 2022, and (RN)-B stated R4's form and she was uniformation. R5's services form, but she did not boxes were marked. The licensee's Services of the licensee's Services of the service	of staff performing delegated apleted within 30 days.  ated January 15, 2022, was ent representative and the vivice plan contained check description of the services fication of staff who will so, and schedule and methods esments; however, none of the service medication administration record wed medication administration hree times a day, this included ctoza (diabetes) injectable  sement dated March 31, 2022, wed bathing, medication blood glucose testing.  It 2:53 p.m. registered nurse service plan was on the old unaware it lacked the correct ervice plan was the current of realize that none of the diameter of the service plan will include: the services that are to be the most recent assessment ences to be provided reach service to be provided recent assessment and					

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.	<del></del>		
		30347	B. WING		06/1	0/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	TH HIAWAT			
	Г	PIPESTO	NE, MN 5610			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01650	Continued From pa	ge 63	01650			
	unlicensed personne. A schedule and rassessment or mor	nethod for the next planned nitoring. nethod for the next planned providing services."				
	TIME PERIOD FOR Twenty-One (21) da					
01700 SS=F	144G.71 Subd. 2 P management service	rovision of medication ces	01700			
	management service providing medication a registered nurse, or authorized presocconduct an assession medication manage provided and how to the transfer of the	nt who requests medication ces, the facility shall, prior to an management services, have licensed health professional, riber under section 151.37 ment to determine what ement services will be he services will be provided. The assessment must include device a review of all medications the betaking. The review and include indications for eactions, and actions to estable to the medications to prevent the total medications and to the resident and legal or intatives on interventions to interventions and preventions are provided and preventions are provided and preventions and preventions are provided and preventions a				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/	10/2022	
	PROVIDER OR SUPPLIER	1101 NOF	DRESS, CITY, S	STATE, ZIP CODE			
FALLS L	ANDING ASSISTED L	PIPESTO	NE, MN 5616	64			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
01700	Continued From pa	ge 64	01700				
	section, "diversion of	tions. For purposes of this of medication" means misuse, proper disposition of					
	by: Based on interview licensee failed to hat for three of three reincluded intervention medications to preventhe resident or othe the medications and resident and legal con interventions to medications to prevention that did no safety but had the president's health or widespread scope (or represent a system).	and document review, the ave a medication assessment sidents (R2, R5, and R7) that ns needed in management of the fent diversion of medication by rs who may have access to diprovide instructions to the or designated representatives manage the resident's rent diversion of medications.  The fent diversion of medications are determined in a level two violation (at tharm a resident's health or cotential to have harmed a safety) and was issued at a twhen problems are pervasive the failure that has affected to affect a large portion or all					
	The findings include	e:					
	identify risk for dive interventions to ma	reatment/Therapy dated April 19, 2021, failed to rsion of medications and nage the residents's ent diversion of medications.					
	failed to identify risk and interventions to	reatment/Therapy dated January 15, 2022, for diversion of medications manage the residents's ent diversion of medications.					

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			(X3) DATE COMP	SURVEY LETED		
		30347	B. WING		06/1	0/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWAT NE, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
01700	Continued From pa	ge 65	01700			
	failed to identify risk and interventions to medication to preve On June 9, 2022, a (RN)-B stated the a required information	dated September 9, 2021, c for diversion of medications o manage the residents's ent diversion of medications.  It 11:00 a.m. registered nurse assessment did not include the regarding drug diversion. The date of the date o				
	The licensee's Med -Assessment, Moni dated August 1, 202 was to include "The interventions neede medications to prevente resident or othe the medications and resident and legal of	dication Management toring & Reassessment policy 21, identified the assessment exassessment must identify and in management of went diversion of medication by the system of the provide instructions to the or designated representatives manage the resident's				
	No further informati	ion was provided.				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
01710 SS=D	144G.71 Subd. 3 In monitoring and reas	ndividualized medication s	01710			
	reassess the reside services as needed resident presents w	facility must monitor and ent's medication management I under subdivision 2 when the vith symptoms or other issues ation-related and, at a				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	NE, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
01710	Continued From pa	age 66	01710			
	minimum, annually					
	This MN Requirem by: Based on interview licensee failed to ei (RN) completed an re-assessments for records reviewed.  This practice result violation that did not safety but had the polient's health or sa cause serious injur was issued at an is limited number of situation has occur.  The findings includ R2's record lacked medication re-assessment that the policy is record lacked medication assession.  On June 9, 2022, as he had not complete assessment that The licensee's Medication management-Asses Reassessment policy identified "[the facilithe resident's medication or other than the policy is medication or other than the policy is medication as needed when the symptoms or other than the policy is medication as needed when the symptoms or other than the policy is medication as the policy is medication as needed when the symptoms or other than the policy is medication as needed when the symptoms or other than the policy is medication as needed when the symptoms or other than the policy is medication as needed when the symptoms or other than the policy is medication in the policy is medication as needed when the symptoms or other than the policy is medication in t	ent is not met as evidenced and record review, the insure the registered nurse nual medication rone of two residents (R2) with a difference of two violation (and the therm a client's health or potential to have harmed a difference of the two violation (and the therm a client's health or potential to have harmed a difference of the violated scope (when one or a difference of the two violated or one or a difference of the two violated scope (when one or a difference of the violated or one or a difference only occasionally).  The most recent ment was dated April 19, 2021.  The the violation of the violation of two violation of two violation of two violations of the violation of the violation of the violation of the violation of two violations of the violation of the violatio				
	No further informat	ion was provided.				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/1	0/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	TH HIAWATI NE, MN 5616			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
01710	Continued From page 67		01710			
	TIME PERIOD FOR CORRECTION: Seven (7) days					
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan		01730			
	management service must prepare and in written statement or services that will be facility must develop individualized mediceach resident base assessment that mr (1) a statement design management service (2) a description of on the resident's nediversion, and considirections; (3) documentation or relating to the admi (4) identification of monitoring medicat medication refills ar (5) identification of tasks that may be of the personnel; (6) procedures for some a problem ari management service (7) any resident-specifications that all	ust contain the following: ceribing the medication ces that will be provided; storage of medications based ceds and preferences, risk of istent with the manufacturer's of specific resident instructions nistration of medications; persons responsible for ion supplies and ensuring that re ordered on a timely basis; medication management lelegated to unlicensed staff notifying a registered e licensed health professional ses with medication				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:				
		30347	B. WING		06/	06/10/2022	
	PROVIDER OR SUPPLIER  ANDING ASSISTED L	IVING 1101 NO	DDRESS, CITY, S RTH HIAWATH DNE, MN 5616	IA AVENUE			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
01730	to prevent possible reactions. (b) The medication current and updates changes. (c) Medication recowhen a licensed nu professional, or aut medication manage.  This MN Requiremed by: Based on observation review, the licensed individualized medication with the required corresidents (R2, R5, a reviewed.  This practice result violation that did not safety but had the president's health or cause serious injury was issued at a pat limited number of rethan a limited number of rethan	complications or adverse  management record must be d when there are any  nciliation must be completed rese, licensed health thorized prescriber is providing ement.  ent is not met as evidenced fon, interview and record efailed to develop an cation management record entent for three of three and R6) with records  ed in a level two violation (and tharm a resident's health or cotential to have harmed a safety, but was not likely to y, impairment, or death) and term scope (when more than a residents are affected, more core of staff are involved, or the red repeatedly; but is not ve).  e:  g services on January 16, mprehensive home care sees that included, but were not dementia, chronic obstructive	t				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/1	0/2022
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWAT NE, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
01730	Continued From pa	ge 69	01730			
	she received assist management.	ance with medication				
	Plan dated April 19 following required c - identification of m	eatment/Therapy Management, 2021, failed to include the content: edication management tasks ted to unlicensed personnel.				
	On June 6, 2022, at 11:16 a.m. unlicensed personnel (ULP)-C administered Incruse Elipta (inhaler to treat chronic obstructive pulmonary disease) to R2.					
	On June 9, 2022, at 9:52 a.m. registered nurse (RN)-B verified R2's Medication/Treatment/Therapy Management Plan did not contain the identification of medication management tasks that may be delegated to unlicensed personnel.					
	R5 R5 began receiving services on January 15, 2022, with diagnoses that included, but were not limited to, diabetes and osteoarthritis.					
		ated January 15, 2022, did not d medication administration.				
		t 6:41 a.m. ULP-E was ng blood glucose monitoring tration for R5.				
	identified she receively the facility staff to	edication administration record ved medication administration hree times a day, this included ctoza (diabetes) injectable				
	R5's Medication/Tre	eatment/Therapy Management				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		30347	B. WING		06/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWATI NE, MN 5610			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	N SHOULD BE COMPLÉTE DATE	
01730	Plan dated January following required of identification of me that may be delegated problems arose; arroblems arose; allowed etc.)  R6 R6 began receiving 2021, with diagnost disease, diabetes apulmonary disease R6's service plandidentified R6 received administration.  R6's 90 Day Assest identified she received administration.  R6's Medication/Troplan dated December the following requirest identification of me that may be delegated.  On June 9, 2022, area, and R6's Medication of me that may be delegated.  The licensee's Medication of me that may be delegated.	v 15, 2022, failed to include the content: edication management tasks ited to unlicensed personnel; aff to notify an RN when ind it-specific requirements (e.g., sugar, blood pressure, pulse, sugar, blood pressure, pulse, it sthat included Alzheimer's and chronic obstructive in ated December 3, 2021, ared assistance with medication is sment dated March 31, 2022, wed medication management. It seatment/Therapy Management is edication management tasks and content edication management tasks ated to unlicensed personnel.	01730			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/1	10/2022
	PROVIDER OR SUPPLIER	IVING 1101 NOI	DDRESS, CITY, S'	IA AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
01730	assessment that m "e. Identification of tasks that may be opersonnel".  No further information	ust contain the following:" medication management lelegated to unlicensed	01730			
01750 SS=I	administration  When administration to unlicensed person must ensure that the (1) instructed the unproper methods to and the unlicensed the ability to compe (2) specified, in write each resident and on the resident's recent (3) communicated was about the individual.  This MN Requirement by:  Based on observation review, the licensed unlicensed person training and comperequired training to This resulted in an July 15, 2022, at ap.  This practice result violation that harments.	with the unlicensed personnel needs of the resident.  ent is not met as evidenced on, interview, and record a failed to ensure one of one neel (ULP-C) completed tency evaluations in all				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/	10/2022
	PROVIDER OR SUPPLIER  ANDING ASSISTED L	IVING 1101 NOF	DRESS, CITY, S RTH HIAWATI NE, MN 5616			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
01750	or a violation that has serious injury, impaissued at a widesprare pervasive or rephas affected or has portion or all of the  The findings include  ULP-C was hired or direct care and servesidents under the license. ULP-C beg services under the August 1, 2021.  On June 6, 2022, awas trained by anot medications. The necompetency test he or other delegated to the or other delegated to observed administers.	as the potential to lead to irment, or death) and was ead scope (when problems present a systemic failure that potential to affect a large residents).  The March 23, 2021, to provide vices to the licensee's comprehensive home care an providing direct care and assisted living licensure on the table of ta		DEFICIENCY)		
	competency testing	record lacked evidence was completed on cations or treatments as				
	was working on formshe had not implement completed the online. They then followed They were then allowed the training and ULI then allowed to pas	t 3:52 p.m. RN-B stated shems for competency testing, but nented that yet. New staff he training and tested on that other ULP for a couple days wed to pass medications with P observing them. Staff were s medications and perform ks independently, RN-B was				

MILLIPSC	Minnesota Department of Health						
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		30347	B. WING		06/1	06/10/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
FALLS L	ANDING ASSISTED L	IVING	TH HIAWATI NE, MN 5610				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
01750	Continued From page 73		01750				
	would observe staff	questions and occasionally RN-B confirmed there was r competency testing N.					
	The licensee's Compolicy dated August registered nurse or staff of [the facility] delegation of service unlicensed personnethods to performeach client and are to competently follow the tasks."  "1. A Registered Nuprofessional where what nursing service properly trained and unlicensed personned. Only unlicensed to be competent an skills consistent with being delegated wild delegated tasks.  3. The Assisted Living place to communate RN regarding currompetencies.  4. Training and competencies.  4. Training and competencies and competencies.	apetency Training Evaluations 1, 2021, identified "When a licensed health professional delegates tasks, prior to the es they must make certain the led is trained in the proper the tasks or procedures for able to demonstrate the ability with the procedures and perform litrse (or other licensed health appropriate) will determine es may be delegated to discompetency tested led. personnel who are determined dispossess the knowledge and the complexity of tasks libe permitted to perform such licate up-to-date information to rent available staff and their lipetency evaluations of ULP's y a RN, or another instructor lining in conjunction with a RN. etency evaluation for led providing assisted living det:" ling medications or treatments					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30347	B. WING	B. WING		10/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE	·	
FALLS L	ANDING ASSISTED L	IVING	ORTH HIAWAT			
(X4) ID PREFIX TAG			ID PREFIX TAG			(X5) COMPLETE DATE
01750	Continued From page 74		01750			
	TIME PERIOD FOR CORRECTION: Immediate  On July 18, 2022, the immediacy of correction order 1750 was removed; however, non-compliance remains at level 3, Widespread (I).  TIME PERIOD FOR CORRECTION: Two (2) days					
01830 SS=F	Prescriptions must months or more fre assessment in subcontrolled substant 152.  This MN Requirem by: Based on observat review, the facility fleast every 12 mon (R2, R4, and R7) w  This practice result violation that did no safety but had the president's health or widespread scope or represent a systematic systematic strength or more free free free free free free free f	Renewal of prescriptions be renewed at least every 12 equently as indicated by the division 2. Prescriptions for ces must comply with chapter ent is not met as evidenced ion, interview and record failed to renew prescriptions at this for three of three resident with record reviewed.  Ted in a level two violation (a of harm a resident's health or potential to have harmed a resafety) and was issued at a (when problems are pervasive emic failure that has affected I to affect a large portion or all	at is			
	The findings includ	e:				
		ysician orders were dated R2's record lacked an annua	ıl			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30347	B. WING		06/10/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWATI NE, MN 5616			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01830	Continued From pa	age 75	01830			
	renewal of physicia	n orders for medications.				
	2016, under the co	g services on January 16, mprehensive home care t 1, 2022, under the assisted				
	R2 had diagnoses that included vascular dementia, chronic obstructive pulmonary disease (COPD), and osteoarthritis.					
	R2's service plan dated August 2, 2021, identified she received assistance with medication management.					
		eatment/Therapy Management , 2021, identified she received stration.				
	personnel (ULP)-C	at 11:16 a.m. unlicensed administered Incruse Elipta onic obstructive pulmonary				
	On June 7, 2022, at approximately 9:12 a.m. ULP-E was observed administering medications to R2.					
	1, 2022, through Ju following medicatio -Brovana (inhaled r -Incruse Elipta (inha	ssion) rgies) lement) sterol)				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		30347		B. WING		06/	10/2022
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING		RTH HIAWATI NE, MN 5610			
(X4) ID PREFIX TAG			BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
01830	-nystatin (for oral ye-omeprazole (gastr-donepazil (dement-furosemide (fluid rosemide (fluid r	east infection) ic reflux) tia) etention) ned signed prescrit listed above dated ere no other more  ysician orders were R2's record lacked er orders for medic y services on Septe mprehensive home 1, 2022, under the t included depress enous insufficiency ated September 24 ed assistance with eatment/Therapy N ber 14, 2021, iden n administration. tt 11:50 a.m. ULP-O medication to R4. tt 6:30 a.m. ULP-D ering eye drops to lead	e dated d an annual cations. ember 13, e care e assisted  ion, anxiety, y.  4, 2020, medication  Management tified he	01830			
	R4's medication ad 1, 2022, through Ju following medicatio	ine 7, 2022, identif	ied the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	30347	B. WING		06/1	06/10/2022	
NAME OF PROVIDER OR SUPPLIER  FALLS LANDING ASSISTED LIVIN	NG 1101 NOR	TH HIAWATI				
PREFIX (EACH DEFICIENCY MUS	MENT OF DEFICIENCIES  IST BE PRECEDED BY FULL  DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
-aspirin (heart health) -multivitamin (supplement) -acetaminophen (pain) -polyethylene glychol (comyrbetriq (increased ucalendronate (osteoporafurosemide (fluid reteralisinopril (heart) -artificial tears (lubricated for the medications listed 17, 2021. There were prescriber orders.  R7 R7's last signed physical February 17, 2021. R7' renewal of physician or R7 began receiving ser 2020, under the compresse and August 1, 2 living license.  R7's diagnoses that increase and August 1, 2 living license.  R7's service plan dated disease, chronic obstruatrial fibrillation, and diagramment.  R7's Medication/Treatment.	hormone replacement)  nent)  constipation) urinary frequency) rosis) ntion)  ting eye drops)  signed prescriber orders ted above dated February no other more recent  cian orders were dated 's record lacked an annual rders for medications.  rvices on September 8, rehensive home care 2022, under the assisted  cluded history of ent (stroke), chronic kidney uctive pulmonary disorder, abetes.  d July 30, 2021, identified	01830				

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	OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
30	0347	B. WING		06/1	0/2022
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FALLS LANDING ASSISTED LIVING		TH HIAWATI NE, MN 5616			
(X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENTIFY)	OF DEFICIENCIES E PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
R7's medication administrated June 1, 2022, through June following medications had be diltiazem (heart) hydrochlorothiazide (fluid remultivitamin (supplement) - Eliquis (atrial fibrillation) - atorvastatin (cholesterol) - vitamin B12 (supplement) - melatonin (sleep) - calcium (supplement) - potassium (supplement) - potassium (supplement)  R7's record contained signate for the medications listed a 17, 2021. There were no operescriber orders.  On June 9, 2022, at 10:05 at (RN)-B confirmed the annuresidents had not been conyear, and she was working completed.  The licensee's Medication at Renewal policy dated Augumand Residents who receive meservices by [the facility] will physician prescribed medication prescribed medication and treatment/therapy orders of and treatment/therapy orders of and treatment orders must every 12 months or more from Medication and treatment/sent to the resident's authosignatures at least every 12 frequently if medications or changed."	ed prescriber orders bove dated February other more recent  a.m. registered nurse all orders for all inpleted in the last on getting them  & Treatment Orders ust 1, 2021, identified edication management have a current eation or in record. Medication be renewed at least requently as required." therapy orders will be inized prescriber for 2 months or more is services are new or	01830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/1	0/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWAT NE, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
01830	Continued From pa	ge 79	01830			
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
01890 SS=E	144G.71 Subd. 20 I	Prescription drugs	01890			
	A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.					
	This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure time sensitive medications were dated when opened and had a pharmacy label for two of two residents (R2 and R3) with records reviewed.					
	violation that did no safety but had the p resident's health or pattern scope (whe of residents are affe number of staff are	ed in a level two violation (a t harm a resident's health or potential to have harmed a safety) and was issued at a n more than a limited number ected, more than a limited involved, or the situation has y; but is not found to be				
	The findings include	e:				
	personnel (ULP)-C (inhaler to treat chro disease) to R2. The	t 11:16 a.m. unlicensed administered Incruse Elipta onic obstructive pulmonary ere was no open date marked be box it was stored in.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30347	B. WING		06/10/2022	
	PROVIDER OR SUPPLIER  ANDING ASSISTED L	IVING 1101 NOR		STATE, ZIP CODE HA AVENUE 64		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01890	On June 6, 2022, a medication cart was was noted R3 had a dated as opened or opened 29 days). Usuadministered that medicate discovered that medica	t 11:21 a.m. a check of the completed with ULP-C. It an open bottle of brimonidine May 8, 2022 (had been ILP-C stated it had been norning and they use eye re gone.  t 3:31 p.m. registered nurse cations should be removed administered after the commended use date.  ufacturer directions dated at: Safely throw away in the trash 6 weeks after you en the counter reads "0", rst. Write the date you open I on the inhaler."	01890			
01910 SS=D	(a) Any current med the assisted living for resident when the r medication manage part of the service p resident who is dec	Disposition of medications dications being managed by acility must be provided to the esident's service plan ends or ement services are no longer plan. Medications for a eased or that have been re expired may be provided for	01910			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		30347	B. WING		06/1	0/2022
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWATH NE, MN 5616			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01910	(b) The facility shal remaining with the expired or upon the contract or the resident federal regulation medications and contract or the resident regulation medications and contract or the resident's recommedication including strength, prescription quantity, to whom to date of disposition, individuals involved. This MN Requirem by:  Based on interview licensee failed upon resident's record the including the medical applicable for one contraction (R9) with record resident's health or isolated scope (where resident's health or isolated scope (where isolated scope (whe	I dispose of any medications facility that are discontinued or termination of the service dent's death according to state ions for disposition of controlled substances.  In, the facility must document in the disposition of the ag the medication's name, con number as applicable, the medications were given, and names of staff and other in the disposition.  The disposition of the medication and record review, the in disposition, document in the disposition of the medication cation's prescription number as of one discharged resident view.  The disposition of the medication cation's prescription number as of one discharged resident view.  The disposition of the medication (and the present of the disposition of the medication of the medication of the medication of the medication and the disposition of the medication				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30347	B. WING		06/10/2022	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWATI NE, MN 5610			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01910	preservision (vitamin Vitamin B12 (supple omeprazole (stoma aspirin (heart health carvedilol (heart), V warfarin (blood thin bringing to the sher They failed to identified On June 10, 2022, (RN)-B stated she v required to record thad not been placin.  The licensee's Med August 1, 2021, ide facility must docum disposition of the m medication's name, as applicable, quan were given, date of staff and other individisposition."	in), grape seed (supplement), ement), furosemide (diuretic), ch reflux), allopurinol (gout), n), amlodipine (heart), (itamin D3 (vitamin), and ner) were destroyed by iff's department drop box. If the prescription number for medications.  at 2:45 p.m. registered nurse was unaware that she was he prescription number and neg that in the form.  ication Disposal policy dated ntified "Upon disposition, the ent in the resident's record the edication including the strength, prescription number tity, to whom the medications disposition, and names of viduals involved in the	01910			
01940 SS=E	144G.72 Subd. 3 In	dividualized treatment or n	01940			
	ordered or prescrib services, the assist and include in the s	eceiving management of ed treatments or therapy ed living facility must prepare ervice plan a written eatment or therapy services				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30347	B. WING	B. WING		10/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	NE, MN 5616			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	that will be provided must also develop individualized treatmanagement record contain at least the (1) a statement of the provided; (2) documentation relating to the treat administration; (3) identification of will be delegated to (4) procedures for appropriate license problem arises with services; and (5) any resident-spudocumentation of the treceived, verification therapy was adminimonitoring of treatment or theraphe current and updichanges.  This MN Requirem by:  Based on observative review, the license implement a treatment or the record to include all five residents (R2, records reviewed.  This practice result violation that did not safety but had the president's health or	d to the resident. The facility and maintain a current ment and therapy of for each resident which must following: the type of services that will be of specific resident instructions				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/10/2022	
NAME OF I	DROVIDED OR SUDDILIED		l.		1 00/1	0/2022
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE HA AVENUE		
FALLS L	ANDING ASSISTED L	IVING	NE, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01940	Continued From pa	ge 84	01940			
	was issued at a pat limited number of re than a limited numb	tern scope (when more than a esidents are affected, more per of staff are involved, or the red repeatedly; but is not				
	The findings include	e:				
	R2 R2 began receiving services on January 16, 2016, under the comprehensive home care license with diagnoses including vascular dementia, chronic obstructive pulmonary disease, and osteoarthritis. R2 began receiving services under the assisted living licensure starting on August 1, 2021.					
	she received TED (hose (compression	ated August 2, 2021, identified thrombo embolic deterrent) stockings to increase uce swelling) assistance.				
	R2's medical record TED hose.	d lacked a physician's order for				
	R2's Medication/Treatment/Therapy Management Plan dated April 19, 2021, failed to include the following:  (1) a statement of the type of services that will be provided;  (2) documentation of specific resident instructions					
	relating to the treating administration; (3) identification of will be delegated to (4) procedures for rappropriate license problem arises with services; and					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
30347	B. WING		06/	10/2022	
NAME OF PROVIDER OR SUPPLIER STREE	T ADDRESS, CITY, ST	TATE, ZIP CODE			
FALLS LANDING ASSISTED LIVING	NORTH HIAWATH STONE, MN 5616				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
documentation of treatment and therapy receiverification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record musbe current and updated when there are any changes.  On June 9, 2022, at 9:52 a.m. registered nurse (RN)-B verified R2's Medication/Treatment/Therapy Management F did not contain the required information for TE hose services.  R4  R4 began receiving services on September 13 2020, under the comprehensive license and began receiving services under the assisted like licensure starting on August 1, 2021. R4 had diagnoses including venous insufficiency, osteoporosis, hypothyroidism and depression.  R4's service plan dated September 4, 2020, identified he received TED hose assistance.  R4's Task Administration record dated June 1, 2022, through June 7, 2022, identified he received TED hose assistance to put of Tubi-Grip socks in the morning. R4's task administration record did not include TED hose assistance.  R4's physician's orders signed on February 17 2021, identified an order for Tubi-Grip stocking to be placed on in the morning and off at night R4's "Medication/Treatment/Therapy Management Plan" dated September 14, 2021	t s s s s s s s s s s s s s s s s s s s				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30347	B. WING		06/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWATI NE, MN 5610			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	(1) a statement of the provided; (2) documentation relating to the treath administration; (3) identification of will be delegated to (4) procedures for appropriate license problem arises with services; and (5) any resident-spedocumentation of the verification that all the administered as protreatment or therap complications or act treatment or therap complications or act treatment or therap be current and updichanges.  On June 9, 2022, and R4's Medication/Traplan did not contain Tubi-Grip socks.  R5 R5 began receiving 2022, with diagnost osteoarthritis.  R5's service pland to identify the service monitoring.	treatment or therapy tasks that unlicensed personnel; notifying a registered nurse or dhealth professional when a treatments or therapy ecific requirements relating to reatment and therapy received, areatment and therapy was escribed, and monitoring of y to prevent possible liverse reactions. The y management record must atted when there are any  t 12:20 p.m. RN-B verified eatment/Therapy Management in the required information for a services on January 15, es including diabetes and eated January 15, 2022, failed the of blood glucose ers identified an order dated blood glucose monitoring daily	01940			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/	10/2022
	PROVIDER OR SUPPLIER  ANDING ASSISTED L	IVING 1101 NOR	DRESS, CITY, S TH HIAWATI NE, MN 5616			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
01940	Management Plan" failed to include the (1) a statement of the provided; (2) documentation or relating to the treatradministration; (3) identification of will be delegated to (4) procedures for rappropriate license problem arises with services; and (5) any resident-spedocumentation of treatment or therap complications or adtreatment or therap complications or adtreatment or therap be current and updachanges.  R5's 90 Day Assessidentified she received on June 8, 2022, a observed supervisinand insulin adminis  On June 9, 2022, a RN-B verified R5's Management Plan of information for blook R6 R6 began receiving 2021, with diagnosed disease, diabetes, it	dated January 15, 2022, following: he type of services that will be of specific resident instructions ments or therapy treatment or therapy tasks that unlicensed personnel; notifying a registered nurse or dihealth professional when a treatments or therapy ecific requirements relating to reatment and therapy received, reatment and therapy was escribed, and monitoring of y to prevent possible verse reactions. The y management record must atted when there are any seement dated March 31, 2022, and blood glucose testing.				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
,	0. 00.11.20.10.1		A. BUILDING:			
		30347	B. WING		06/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EALLSI	ANDING ASSISTED L	IVING 1101 NOR	TH HIAWATI	HA AVENUE		
TALLOL	ANDING AGGIGTED E	PIPESTO	NE, MN 5610	64		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01940	Continued From pa	ge 88	01940			
	disease.					
	uisease.					
	identified R6 receiv	ated December 3, 2021, ed assistance with blood and TED hose administration.				
	R6's 90 Day Assessment dated March 31, 2022, identified she received blood glucose testing.					
	R6's medical record included a Continuity of Care Document (Ambulatory Clinical Summary) dated November 29, 2021, identified by RN-B to be physician's orders. The document lacked a physician signature or electronic signature on the document. It included an order for blood glucose monitoring once daily and an order for compression stockings use as directed.					
	R6's Medication/Treatment/Therapy Management Plan dated December 1, 2021, failed to include the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy was					
	treatment or therap complications or ac treatment or therap	escribed, and monitoring of y to prevent possible lverse reactions. The y management record must ated when there are any				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		30347	B. WING	B. WING		06/10/2022	
	PROVIDER OR SUPPLIER  ANDING ASSISTED L	IVING 1101 NOF	DRESS, CITY, S RTH HIAWATH NE, MN 5616				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
01940	Medication/Treatmedid not include blood hose administration.  R8 R8 began receiving 2020, under the corlicense and began rassisted living licen 2021. R8's diagnos mellitus, macular dekidney disease.  R8's service plan daidentified he received.  R8's apartment, addicompleted blood glicense and began rassisted living licen 2021. R8's diagnos mellitus, macular dekidney disease.  R8's service plan daidentified he received.  R8's apartment, addicompleted blood glicensed.  R4's physicians ord 2021, included and completed blood glicensed.  R4's physicians ord 2021, included and completed blood glicensed.  R4's physicians ord 2021, included and plant and off in the p.m.  R8's Medication/Treplan dated August 2 following: (1) a statement of the provided; (2) documentation of the provided of the provided; (2) documentation of the provided of t	t 9:52 a.m. RN-B verified R6's ent/Therapy Management Pland glucose monitoring and TED in services on December 30, imprehensive home care receiving services under the sure starting on August 1, ses included type 2 diabetes regeneration, and chronic ated August 27, 2021, red blood glucose testing.  It 6:30 a.m. ULP-D entered ministered oral medication and ucose testing. ULP-D assisted teral knee braces and getting rers signed on February 17, order for blood glucose hysician's order dated March al knee braces on in the a.m.  Reatment/Therapy Management 20, 2021, failed to include the the type of services that will be of specific resident instructions	01940	DELIGITIES !			
	relating to the treatr administration; (3) identification of	nents or therapy treatment or therapy tasks that					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/1	10/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
FALLS I	ANDING ASSISTED L	IVING	RTH HIAWATH ONE, MN 5616			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	will be delegated to (4) procedures for appropriate license problem arises with services; and (5) any resident-sp documentation of the verification that all administered as protreatment or therapt complications or act treatment or therapt be current and upded changes.  On June 9, 2022, a RN-B verified R8's Management Plan information for blocknee braces.  The licensee's Med Administration & D 1, 2021, identified medications or treatment or the assigned to unlicer Assisted Living will nurse has:  1. Instructed the of the proper methods to administer the more treatment/therapy, demonstrated the approcedures 2. Specified, in we each resident and on the resident's red about the individual	o unlicensed personnel; notifying a registered nurse or and health professional when an treatments or therapy ecific requirements relating to reatment and therapy received treatment and therapy was escribed, and monitoring of by to prevent possible diverse reactions. The by management record must atted when there are any attack when there are any did not contain the required and glucose monitoring and dication & Treatment - elegation policy dated August When administration of atment/therapy is delegated or unsed personnel, Falls Landing ensure that the registered unlicensed personnel (ULP) in swith respect to each resident nedications or perform and the ULP has ability to competently follow the criting, specific instructions for documented those instructions				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED			
				A. BUILDING:				
		3034	17	B. WING		06/	06/10/2022	
NAME OF PROVIDER O	R SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
FALLS LANDING A	SSISTED L	IVING		TH HIAWATI				
PREFIX (EACH	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		RECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
administr following 1. A RN assessm manager be provided for for provided for provid	must occul must con ent to determent or tree ded and how the second of t	or treatment or treatment or treatment what atment/the will prepare the statement or treatment or medical or	eatment/therapy to the resident. rrent prescriber's ing, specific and document ents' record. LP on the following ks before delegating of checking a tration record ation for medication to the inister medications. assistance with cation ne, dosage, and I medications, or ith medication d the initials of the no assisted or	01940				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30347	B. WING		06/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWATI			
	I		NE, MN 5610			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
01940	Continued From pa	ge 92	01940			
	competency testing administration and	of delegated medication treatment/therapy."				
	No further informati	on provided.				
	TIME PERIOD FOR days.	R CORRECTION: Seven (7)				
01950 SS=F	144G.72 Subd. 4 A	dministration of treatments	01950			
	must be administer other licensed healt perform the treatmed delegated or assign the licensed health appropriate practice assignment. When or therapy is delegated personnel, the facili registered nurse or professional has:  (1) instructed the urproper methods with the unlicensed persability to competent (2) specified, in write each resident and in the resident and in the resident's recion (3) communicated wabout the individual.  This MN Requirements by:  Based on observation review, the licensed personnel were train	red treatments or therapies ed by a nurse, physician, or the professional authorized to ent or therapy, or may be sed to unlicensed personnel by professional according to the estandards for delegation or administration of a treatment sted or assigned to unlicensed ty must ensure that the authorized licensed health enlicensed personnel in the herespect to each resident and connel has demonstrated the ly follow the procedures; ing, specific instructions for documented those instructions for documented those instructions for documented those instructions end; and with the unlicensed personnel needs of the resident.  The ent is not met as evidenced end and demonstrated the end and demonstrated the end and demonstrated the end and demonstrated the ents to a registered nurse				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30347	B. WING		06/1	0/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWATI NE, MN 5610			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01950	Continued From pa	nge 93	01950			
	(RN) for three of three unlicensed personnel (ULP-C, ULP-D and ULP-E) with records reviewed.					
	violation that did no safety but had the p resident's health or widespread scope or represent a system	ed in a level two violation (a of harm a resident's health or cotential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all				
	The findings includ	e:				
	ULP-C ULP-C was hired on March 23, 2021, to provide direct care and services to the licensee's residents under the comprehensive home care license. ULP-C began providing direct care and services under the assisted living licensure on August 1, 2021.					
	was trained by ano medications. The name competency test he administration, TEI hose (compression vascularity and decomplete)	that 11:13 a.m. ULP-C stated she ther ULP on how to administer turse did not train or er on medication (thrombo embolic deterrent) a stockings used to increase crease swelling) placement, itoring or other delegated				
	observed administe	at 11:16 a.m. ULP-C was ering medication to R7, and at ninistered medication to R4.				
		sk Administration Record ad applied TED hose on May 4, 2022.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30347	B. WING		06/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	NE, MN 5610			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01950	Continued From page 94		01950			
	R4's June 2022, Task Administration Record identified ULP-C had applied Tubi-Grip socks on June 1, 2022.					
	R7's June 2022, Task Administration Record identified ULP-C had applied TED hose on June 1, 3 and 6, 2022.					
	identified ULP-C hamonitoring on June	ask Administration Record ad performed blood glucose at 1, 2022. ULP-C had placed as on June 6, 2022.				
	ULP-C's employee record lacked evidence training and competency testing was completed by an RN for TED hose, Tubi-Grip socks, blood glucose monitoring, or brace placement.					
	ULP-D ULP- D was hired on June 11, 2018, to provide direct care and services to the licensee's residents under the comprehensive home care license. ULP-D began providing direct care and services under the assisted living licensure on August 1, 2021.					
	ULP-D was observ performing blood g	t approximately 6:40 a.m. ed administering medications, lucose monitoring, applying knees, and assisting R8 with				
		sk Administration Record ad applied TED hose on May 3, 4, 2022.				
		sk Administration Record ad applied Tubi-Grip socks on				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/	10/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWATH NE, MN 5616			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
01950	Continued From pa	ge 95	01950			
	identified ULP-D ha monitoring on June	sk Administration Record of performed blood glucose 5 and 7, 2022. ULP-D had e braces on June 5 and 7,				
	training and compe by an RN for TED h	record lacked evidence tency testing was completed lose, Tubi-Grip socks, blood , or brace placement.				
	ULP-E On June 8, 2022, at 6:41 a.m. ULP-E was observed supervising blood glucose monitoring and insulin administration for R5. ULP-E stated she was trained by another ULP for blood glucose monitoring and insulin administration.					
		sk Administration Record d applied TED hose on June 2				
		sk Administration Record d placed bilateral knee braces				
	was working on formshe had not implement completed an online tested on that. Then couple days. New somedications and perwith the training UL could pass medicated delegated tasks indicavailable to answer would observe staff	t 3:52 p.m. RN-B stated shems for competency testing, but nented that yet. New staff e training (Educare) and they followed other ULP for a staff were allowed to pass erform other delegated tasks P observing them. Then, staff ions and perform other dependently. RN-B was questions and occasionally She confirmed there was no ompetency testing completed				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CONTROL OF TOTAL	BENTI TOATION NOMBER.	A. BUILDING:	<del></del>	COIVII	LLILD
		30347	B. WING		06/10/2022	
					1 00/1	0/2022
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S T <b>H HIAWAT</b> I	STATE, ZIP CODE		
FALLS LANDING ASSISTED LIVING		IVING	NE, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
01950	Continued From page 96		01950			
	by the RN.					
	policy dated August registered nurse or staff of [the facility] delegation of servicu unlicensed personn methods to perform each client and are to competently follothe tasks."  "1. A Registered Nuprofessional where what nursing service properly trained and unlicensed personn 2. Only unlicensed to be competent an skills consistent with being delegated will delegated tasks.  3. The Assisted Livin place to communa RN regarding currompetencies.  4. Training and comwill be conducted be may provide the tra RN."  5. "Training and conuncensed personn services must inclusive and services and se	personnel who are determined d possess the knowledge and h the complexity of tasks I be permitted to perform such ing facility will have a system place up-to-date information to rent available staff and their inpetency evaluations of ULP's y a RN, or another instructor ining in conjunction with a impetency evaluation for place providing assisted living de:  g medications or treatments				
	as required"  No further informati					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30347	B. WING		06/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWAT NE, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
01970 SS=D	There must be an uselectronically record prescriber for all tresponded and the frinformation needed therapy. Treatment renewed at least eventual the license of the fortwo of five resident reviewed.  This practice results violation that did not safety but had the president's health or cause serious injury was issued at a pat limited number of rethan a limited nu	ded order from an authorized satments and therapies. The the name of the resident, a eatment or therapy to be requency, duration, and other to administer the treatment or and therapy orders must be rery 12 months.  The tild is not met as evidenced on, interview and record on, interview and record or a treatment was obtained ents (R2 and R6) with records that is not met as evidenced on a level two violation (a tharm a resident's health or other to have harmed a safety, but was not likely to y, impairment, or death) and tern scope (when more than a residents are affected, more or of staff are involved, or the red repeatedly; but is not ve).				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/	10/2022
				TATE, ZIP CODE HA AVENUE 64		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF T	ULD BE	(X5) COMPLETE DATE
01970	August 1, 2021.  R2's service plan do she received TED (hose (compression vascularity and deconstruction of the property of th	ated August 2, 2021, identified thrombo embolic deterrent) s stockings that increase rease swelling) assistance.  a physician's order for the ose.  t 9:52 a.m. registered nurse s physician's orders did not	01970			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/	10/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FALLSI	ANDING ASSISTED L	IVING	TH HIAWATI			
		PIPESTO	NE, MN 5610	64		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
01970	Continued From pa	ge 99	01970			
	signature.					
	Administration & De 1, 2021, identified "medications or trea assigned to unlicen Assisted Living will nurse has:  1. Instructed the unither proper methods to administer the mitreatment/therapy, additional demonstrated the approcedures  2. Specified, in write each resident and on the resident and on the resident and of the individual "Prior to a ULP provided about the individual "Prior to a ULP provided and in the resident of the medication and following must occur.  1. A RN must contassessment to deterministration and following must occur.  2. Falls Landing A include in the Service the medication man services that will be 3. The medication orders on file.  4. A RN must specinstructions for each those instructions in 5. A RN must instructions in 5.	bility to competently follow the iting, specific instructions for documented those instructions cords with the unlicensed personnel needs of the resident." viding delegated medication or treatments/therapy, the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30347	B. WING		06/1	0/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	TH HIAWATI NE, MN 5616			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
01970	a) The complete president's medication (MAR). b) The preparation administration. c) The administration. c) The administration resident. d) The reminder to e) The documents medication reminder administration, of the method of administration as on nurse or authorized administration as on nurse or authorized administered and of administration or tree. The ULP must competently follow administration or tree. Written records maintained regarding competency testing administration and the No further information.	procedure of checking a con administration record an of medication for tion of the medication to the conself-administer medications. Attion after assistance with the constraint of all medications, or assisting with medication and the initials of the person who assisted or assisted or assisted or assisted the person who assisted or assisted the person who assisted or assisted the same. The delegated medication are atment/therapy to a RN. As signed by a RN, shall be and ULP training and of delegated medication treatment/therapy."	01970			
02310 SS=G	(a) Residents have living services that resident's needs an service plan subject standards.	ppropriate care and services the right to care and assisted are appropriate based on the d according to an up-to-date t to accepted health care ent is not met as evidenced	02310			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30347	B. WING		06/	10/2022
				TATE, ZIP CODE IA AVENUE 4		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EA	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
02310	Based on observation review, the licensesservices were providealth care and merone of one resident siderails, with record an immediate correct at 10:00 a.m.  This practice result violation that harmone including serious or a violation that has serious injury, impaissued at an isolate limited number of real limited number of situation has occurred. The findings included On June 6, 2022, a observed bilateral has reviewed as a diagnosis including the knee, as thma, at R2's service plander R2 received assistated administration, and R2's "Side Rail/Assist Bar Evalued it for reposition and to promote indefurther identified R2 received as the received a	on, interview, and record e failed to ensure the care and ded according to acceptable dical, or nursing standards for (R2) with bilateral half dreviewed. This resulted in action order on June 6, 2022, ed in a level three violation (and a resident's health or safety, as injury, impairment, or death, as the potential to lead to a similar in the potential to lead to a similar in the potential to lead to a similar in the potential to lead to a sesidents are affected or one or a staff are involved or the ared only occasionally).				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7 11 20122 11 101			
		30347	B. WING		06/	10/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	ORTH HIAWATI			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
02310	0 Continued From page 102		02310			
	bed had a half siderail on the left side. The assessment also failed to identify measurements for zones of entrapment, risks and benefits of siderails had been discussed with resident or family, and mitigation of risk had been attempted by the licensee.					
	On June 6, 2022, at 9:21 a.m. registered nurse (RN-B) stated that R2's bed had the siderails in place prior to start of her employment. She had asked R2 in the past if she wanted the siderails and if she used them. RN-B updated the assessment annually. RN-B further indicated being aware of the FDA Side Rail Entrapment Zones and Dimensional Recommendations; however, she had not measured the siderails. RN-B further confirmed the risks and benefits of side rail use had not been completed with the family or the resident, and no mitigation of risk had been attempted by the licensee.					
	On June 6, 2022, at approximately 9:30 a.m. RN-B completed measurements for R2's siderails with the surveyor present. The half siderails opening was found to be 4.5 inches wide between the bars and 17 inches high. The gap between the siderails and the headboard was 5 inches. In addition, under the bed, the siderail system was to be attached by two screws on each side of the bed. On the left side of the bed, one of the two screws was loose and not attached to the bed frame. This caused the side rail to be easily lifted up on that side of the bed, when lightly compressed the mattress to rail gap was greater then 4.75 inches. RN-B confirmed that it was possible for R2 to get entrapped within the openings.  The March 10, 2006, FDA Side Rail Entrapment		n n			
		6, FDA Side Rail Entrapment ional Recommendations				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		30347	B. WING		06/	10/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	RTH HIAWATI ONE, MN 5610			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
02310	indicated to reduce (space between the four and three quare The Food and Drug Guide to Bed Safet the following informused, perform an opatient's physical a monitor high-risk paidentified; "Patients memory, sleeping, uncontrolled body red and walk unsabe carefully assess them from harm, suthe patient's health determine how bes.  The licensee's Side 2021, identified "Whome care resident medical device) on the use, educate the appropriate, the resthe risks and benefithe side rail in use consistent with the This policy shall be owns or is supplyin "PROCEDURE-AS When side rails are an assessment to ithe side rail and the side rail. If the side appropriate actions "PROCEDURE-VE IS SAFE:	the risk of entrapment, zone e rails), should be less than rters' inches.  g Administration (FDA), "A cy" revised April 2010, included nation: "When bed rails are in-going assessment of the nd mental status, closely attents. The FDA also who have problems with incontinence, pain, movement, or who get out of fely without assistance, must sed for the best ways to keep uch as falling. Assessment by care team will help to set to keep the patient safe."  The rails policy dated August 1, hen [licensee] is aware a trial is utilizing side rails (a a bed, [licensee] will assess the resident, and when sponsible person, regarding fits of side rails, and verify that is of a safe design and utilized manufacturer's directions. If followed regardless of who g the side rail."  SESSMENT:  The in use, an RN must conduct dentify the intended purpose of the rail is acting as a restraint,				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		B. WING		06/1	0/2022	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FALLS L	ANDING ASSISTED L	IVING	TH HIAWATI NE, MN 5610	HA AVENUE 64		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
02310	defined as meeting below:  a. The side rail is manufacturer's dire that slide between the designed for toddle between the side rails a maintained in good of "wobbly" side rail company to the side rail designed for toddle between the side rails a maintained in good of "wobbly" side rail company to the side rail designed reside rail zon the side rail zon	all of the requirements listed used consistent with ctions. Be aware of side rails the mattress and box spring ruse. The installed securely and operating condition. Be aware as a sign is consistent with the mended dimensional educe entrapment. This tes 1,2, and 3 must not exceed UCATION:  When appropriate, the tative, shall be informed of the egarding the use of side rails. Will be documented in the	02310			



Minnesota Department of Health Food, Pool, & Lodging Services P.O. Box 64975 Saint Paul, MN 55164-0975 651-201-4500

Type: Full
Date: 06/06/22
Time: 10:55:17
Report: 1020221063

# Food and Beverage Establishment Inspection Report

Page 1

	ion:

Falls Landing Assisted Living 1101 North Hiawatha Avenue

Pipestone, MN56164 Pipestone County, 59

License Cat	egories:
-------------	----------

Expires on: //

#### Establishment Info:

ID#: 0038319

Risk:

Announced Inspection: No

## Operator:

Phone #: 5075626648

ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

## 4-700 Sanitizing Equipment and Utensils

### 4-703.11B

\*\* Priority 1 \*\*

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

HIGH TEMPERATURE DISHWASHER USED AT THE ESTABLISHMENT. PROVIDE AN IRREVERSIBLE TEMPERATURE INDICATOR TO ENSURE THE UTENSIL SURFACE TEMPERATURE REACHES 160F. EXAMPLES INCLUDE A MIN/MAX THERMOMETER, DISHTEMP, AND THERMOLABELS. USE MULTIPLE TIMES A WEEK.

Comply By: 06/24/22

### **4-100** Equipment Construction Materials

### 4-101.11BCDE

MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.

ICE CREAM BUCKET BEING RE-USED FOR FOOD STORAGE; USE FOOD GRADE FOOD STORAGE CONTAINERS TO STORE THE FOOD ITEMS IN THE ESTABLISHMENT.

Comply By: 06/07/22

Type: Full
Date: 06/06/22
Time: 10:55:17
Report: 1020221063

## Food and Beverage Establishment Inspection Report

Falls Landing Assisted Living

### 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

SOME CABINET DOOR FINISHES ARE BEGINNING TO SEPARATE FROM THE DOOR EXPOSING THE BARE WOOD; REPAIR SO THE SURFACE IS SMOOTH AND NON-ABSORBENT.

Comply By: 09/30/22

### **Surface and Equipment Sanitizers**

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit

Location: SANITIZER BUCKET

Violation Issued: No

Wash Temperature Gauge: = at 154 Degrees Fahrenheit

Location: DISHWASHER Violation Issued: No

Final Rinse Temperature Ga: = at 184 Degrees Fahrenheit

Location: DISHWASHER Violation Issued: No

Utensil Surface Temperatur: = at 170 Degrees Fahrenheit

Location: DISHWASHER Violation Issued: No

### **Food and Equipment Temperatures**

Process/Item: Cold Holding

Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - CHEST FREEZER, BACK STORAGE

Violation Issued: No

Process/Item: Cold Holding

Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - UPRIGHT FREEZER, BACK STORAGE

Violation Issued: No

Process/Item: Cold Holding

Temperature: 37 Degrees Fahrenheit - Location: MILK - UPRIGHT COOLER, BACK STORAGE

Violation Issued: No

Process/Item: Cold Holding

Temperature: 37 Degrees Fahrenheit - Location: SWEET POTATOES - UPRIGHT COOLER

Violation Issued: No

Process/Item: Cold Holding

Temperature: 37 Degrees Fahrenheit - Location: CHICKEN AND SPINACH STUFFED SHELLS - WHITE

UPRIGHT COOLER Violation Issued: No

Process/Item: Cold Holding

Temperature: 38 Degrees Fahrenheit - Location: PASTA - SILVER UPRIGHT COOLER

Violation Issued: No

Page 3

Type: Full
Date: 06/06/22
Time: 10:55:17
Report: 1020221063

# Food and Beverage Establishment Inspection Report

Falls Landing Assisted Living

Total O	rders	In This Report	Priority 1	Priority 2	Priority 3
			1	0	2

### **GENERAL COMMENTS:**

DISCUSSED COVID-19 AND EMPLOYEE ILLNESS POLICIES AND PROCEDURES. AN EMPLOYEE ILLNESS LOG AND ILLNESS REPORTING REQUIREMENTS FACT SHEET WAS PROVIDED WITH THE REPORT.

DISCUSSED COOLING AND RE-HEATING PROCEDURES. A FACT SHEET ON COOLING TIME/TEMPERATURE CONTROL FOR SAFETY FOODS AND A COOLING LOG WAS PROVIDED WITH THE REPORT.

A THERMOMETER CALIBRATION LOG WAS PROVIDED WITH THE REPORT.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1020221063 of 06/06/22.

Certified Food Protection	rtified Food Protection Manager Jennifer Currier								
Certification Number:	FM63285	Expires:	06/16/24						

Inspection report reviewed with person in charge and emailed.

igned: Nepur C CMM/140

Establishment Representative

igned.

651-201-4500

Report #: 10202210	63	Food Establis	hn	nei	nt Ir	nsr	ectio	n Repo	rt				
Minnesota Department of Health				1								6/06/2	2
	Food, Pool, & Lodging Services P.O. Box 64975			No. of Repeat RF/PHI Cate			t RF/PHI Cate	gories Out	0	Time In 1	0:55:1	7	
DEPARTMENT OF HEALTH	Saint Paul, MN 55164-0975					L	egal Author	ity MN Rules	Chapter 4626		Time Out		
Falls Landing Assisted	d Living	Address 1101 North Hiawatha Avenue				y/Sta	te ne, MN		Zip Code 56164		phone 5626648		
License/Permit #		Permit Holder					of Inspection	on	Est Type	307	Risk Catego	orv	
0038319					Fu	•						,	
		ORNE ILLNESS RISK FAC	_	RS A	ND P	UBI	IC HEAL	TH INTERV	ENTIONS				
		us (IN, OUT, N/O, N/A) for each numbered				-1-1-			'X" in appropriate box				
IN= in compliance	OUT= not in comp	oliance N/O= not observed	1	<del>.</del>	ot applic				site during inspection		R= repeat v		
Compliance Sta		Surpervision	CO	\$ R		Con	pliance St		nperature Contro	I for Sa	nfetv	СО	s R
1 (IN) OUT PIC knowledgeable; duties & oversight			П	18	IN C	OUT N/A( N/C		ng time & tempera				Т	
2 IN OUT N/A Certified food protection manager, duties			Ц	19	IN C	OUT N/A(N/C	Proper rehea	ating procedures fo	or hot h	olding			
2/ 2/ 2/ 2		nployee Health	Г		20		DUT N/A(N/C		ng time & tempera				
3 (IN) OUT	,	dge,responsibilities&reporting rting, restriction & exclusion		$\vdash$		$\overline{}$	$\overline{}$		olding temperature				
4 (IN) OUT		ponding to vomiting & diarrheal				-	OUT N/A	<u> </u>	nolding temperatur				
<sup>5</sup> (N) OUT	events				$\rightarrow$	$\sim$	$\overline{}$		marking & disposit		duras e rasardo	_	+
6 (IN) OUT N/O		lygenic Practices ing, drinking, or tobacco use			24	IIN C	JO (N/A) N/C	<u> </u>	sumer Advisorv	. proced	unes & records	·	
1,75	1 0	eyes, nose, & mouth		$\forall$	25	IN C	DUT(N/A)		dvisory provided for	or raw/u	indercooked for	od	
1,00		ontamination by Hands							usceptible Popula				
8 IN OUT N/O	Hands clean & pro	pperly washed			26	IN C	DUT(N/A)		foods used; prohib				
9 IN OUT N/A N/O		tact with RTE foods or pre-approved			27	INI C	NIT NIA	1	olor Additives an				
10 IN OUT	alternate pprocess	ure properly followed shing sinks supplied/accessible				IN C	DUT(N/A)		es: approved & pro nces properly ider	-			+
- 331	<u> </u>	oved Source			20		701		e with Approved				
1 IN OUT		m approved source			29	IN C	DUT(N/A)	Compliance	with variance/spec	ialized	process/HACC	P	Т
12 IN OUT N/A N/O	Food received at p	roper temperature						-					_
13(IN) OUT		lition, safe, & unadulterated											
14 IN OUT( N/A) N/O	Required records a parasite destruction	available; shellstock tags, n			Biol	, foot	ara (BE) oro i	mpropor proofi	oos or proceedure	a idanti	find on the mos	.+	
	'	om Contamination			prev	alent	contributing f	factors of foodb	ces or proceedure oorne illness or inju	ıry. <b>Pu</b> k	olic Health Inte	rventi	ons
15 IN) OUT N/A N/C	Food separated ar	nd protected			(PHI	) are	control meas	ures to preven	t foodborne illness	or inju	ry.		
16 IN (OUT)N/A	Food contact surfa	ces: cleaned & sanitized											
17 (IN) OUT		of returned, previously served,											
	reconditioned, & u			CT/	\ II D	340	TIOFO						
Goo	d Patail Practices	are preventative measures to control					TICES	lls and physica	al objects into food	9			
Mark "X" in box if nu						_	COS and/or I		corrected on-site du		ection R= repe	at viola	tion
			cos	R								cos	R
	Safe Food an	d Water					T.	•	er Use of Utensils	3			
30 IN OUT N/A	Pasteurized egg	s used where required			43			nsils: properly s					
31 Water & i	ice obtained from ar	approved source			44			· ·	ens: properly store		<u>′</u>		
32 IN OUT(N/A)	Variance obtained	for specialized processing methods			45				articles: properly s	stored 8	& used		
	Food Temperatu	ure Control			46		Gloves use	ed properly	quipment and Ve	ndina			
33 Proper coo	oling methods used;	adequate equipment for			47	Х			surfaces cleanable		erly		
34 IN OUT(N/A)	N/O Plant food pro	perly cooked for hot holding		$\neg$	48		-		stalled, maintained	d, & use	ed; test strips		
	_	wing methods used		$\neg$	49			contact surface					
35  ( IN ) OUT N/A 1		wing mounded dood			.0				ysical Facilities			1	
	eters provided & acc				50		Hot & cold	water available	e; adequate pressi				
	eters provided & acc Food Identi	curate			50					ure			
36 Thermome	<u> </u>	curate fication			51		Plumbing i	nstalled; prope	r backflow devices				
36 Thermome 37 Food prop	Food Identi erly labled; original Prevention of Fo	curate fication container od Contamination			-		_		r backflow devices				
36 Thermome 37 Food prop 38 Insects, ro	Food Identi erly labled; original Prevention of Food dents, & animals no	curate fication container od Contamination t present			51		Sewage &	waste water p		3	eaned		
36 Thermome  37 Food prop  38 Insects, ro  39 Contamina	Food Identi erly labled; original Prevention of Foodents, & animals no ation prevented during	curate fication container od Contamination			51 52		Sewage & Toilet facili	waste water p	roperly disposed	ed, & cl			
37 Food prop  38 Insects, ro 39 Contamina 40 Personal c	Food Identi erly labled; original Prevention of Foodents, & animals no dents, & animals no ation prevented during leanliness	curate fication container od Contamination t present ng food prep, storage & display			51 52 53	X	Sewage & Toilet facili Garbage &	waste water pointies: properly control of the contr	roperly disposed constructed, supplie	ed, & cl			
37 Food prop 38 Insects, ro 39 Contamina 40 Personal c 41 Wiping clo	Food Identical Food I	curate fication container od Contamination t present ng food prep, storage & display			51 52 53 54 55 56	X	Sewage & Toilet facili Garbage & Physical fa Adequate	waste water p ities: properly c refuse proper acilities installed ventilation & lig	roperly disposed constructed, supplied by disposed; facilities	ed, & cl es mair ean	ntained		
36 Thermome  37 Food prop  38 Insects, ro  39 Contamina  40 Personal c  41 Wiping clo	Food Identi erly labled; original Prevention of Foodents, & animals no dents, & animals no ation prevented during leanliness	curate fication container od Contamination t present ng food prep, storage & display			51 52 53 54 55 56 57	X	Sewage & Toilet facili Garbage & Physical fa Adequate Compliance	waste water p ities: properly of a refuse proper acilities installed eventilation & light re with MCIAA	roperly disposed constructed, suppli- ly disposed; faciliti d, maintained, & cl hting; designated	ed, & cl es mair ean	ntained		
36 Thermome  37 Food prop  38 Insects, ro  39 Contamina  40 Personal c  41 Wiping clo	Food Identical Food I	curate fication container od Contamination t present ng food prep, storage & display			51 52 53 54 55 56	X	Sewage & Toilet facili Garbage & Physical fa Adequate Compliance	waste water p ities: properly of a refuse proper acilities installed eventilation & light re with MCIAA	roperly disposed constructed, supplied by disposed; facilitied, maintained, & cl	ed, & cl es mair ean	ntained		
36 Thermome  37 Food prop  38 Insects, ro  39 Contamina  40 Personal c  41 Wiping clo  42 Washing fr	Food Identical Food I	curate  fication  container  od Contamination  t present  ng food prep, storage & display  a stored			51 52 53 54 55 56 57	X	Sewage & Toilet facili Garbage & Physical fa Adequate Compliance	waste water p ities: properly of a refuse proper acilities installed eventilation & light re with MCIAA	roperly disposed constructed, suppli- ly disposed; faciliti d, maintained, & cl hting; designated	ed, & cl es mair ean	ntained		

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